The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-TWO *NUMBER SIX*

MONTREAL, JUNE, 1946

Talking about Ourselves

MANY YEARS AGO Miss Adelaide Nutting, Professor Emeritus, Department of Nursing Education, Columbia University, said, "Let no one ignore the journals of the country. The first faltering steps towards organization, legislation and education—are always found in a little sheet or journal—something in which the nurses' problems are set forth." Ever since its inception *The Canadian Nurse* has performed this function. It has long since passed the "little sheet" stage but today as never before there is need for a distinctively Canadian medium for presenting the problems of nurses and nursing in Canada. The journals of other countries, no matter how excellent, can never fill this particular need.

Louisa M. Alcott once said, "That is a good book, it seems to me, which is opened with expectation and closed with profit." We feel that this is true of every issue of *The Canadian Nurse*. This June number marks another milestone in the history of our national *Journal* for our editor and business manager assumed her duties just two years or twenty-four issues ago. The healthy state of the circulation of the *Journal* today and the marked increase in the quantity of available subject matter must be as gratifying to the readers of the *Journal* as it is to the editor and her Editorial Board. From small beginnings the annual budget of the *Journal* is now over $25,000 a year. Since the *Journal* is a non-profit making undertaking, as soon as a reasonable reserve fund had been invested in Victory Bonds, it was decided that the proceeds should be put back into the building of a bigger and better magazine, and so it happens that the subscribers are now receiving larger dividends in the form of improvements in the *Journal* itself. One of the outstanding improvements is in the physical appearance of the *Journal*, which, commencing with the April issue, was in the hands of a new printer. The editor could tell you in technical language just what the new contract means, but to the majority

of readers it may be interpreted as providing a clearer type which makes for easier reading, more attractive and satisfying pages, better illustrations, and last, but not least, more regular distribution in the months to come. Other changes will be made as conditions warrant them.

Another step which has been taken recently should increase the usefulness of the content of the *Journal*. "Editorial Consultants" have been named in each province to assist the editor in securing first-hand information regarding the interests and needs of the nurses in all parts of Canada. The following nurses have accepted this post in their respective provinces. Let them know what topics you would like to have developed into articles:

Alberta, Margaret O. Cogswell; *British Columbia*, Elizabeth Braund; *Manitoba*, Anna W. Spence; *New Brunswick*, Muriel E. Hunter; *Prince Edward Island*, Ruth I. Ross; *Ontario*, Dorothy G. Riddell; *Quebec*, Winnifred MacLean, Suzanne Giroux; *Saskatchewan*, Grace Giles.

So much for the new exterior and the machinery for adjusting the interior to meet readers' requirements even more adequately.

In the latest issue of *The Quarterly*, a publication of the Toronto General Hospital Alumnae Association, reference is made to the value which should accrue from being a regular subscriber to *The Canadian Nurse*. The following quotation demonstrates the faith this group has in the *Journal:*

> The public looks to the graduate nurse to be a leader in her profession—but how many of us can talk intelligently on current nursing issues or discuss freely topics concerned with the so-called "specialties", public health, psychiatry, etc.? We refuse, most of us, to leave the sheltered cloister of our own training school and to get out into the nursing world and learn about the varied problems and activities which are vital to every Canadian nurse today. Nursing is a progressive art, and to be truly proficient the nurse must possess all the information that can be obtained. The tremendous strides which are being made by scientists in the fields of preventive medicine, surgery, nutrition, etc., make it impossible for a fully qualified nurse of the present day and age to learn all that it is necessary to know by practice alone.
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> *The Canadian Nurse* is the only authoritative publication issued exclusively for the instruction and edification of Canadian nurses. It is ably edited, and its subject matter is of such nature that it compares favourably with any magazine of similar character in any country in the world. Well-known experts and authorities on education, medicine, and nursing contribute to its pages, and much encouragement is given to student nurses to contribute stimulating articles which will be of especial interest and assistance to the student body as a whole. *The Canadian Nurse* should be in the hands of every nurse who is anxious to keep abreast of the times and to be a valuable member of her profession.

The post-war days for which we all longed during the days of war have brought new problems to add to the many unsolved ones which were the legacy of the war years and before. These must be faced and solutions found before the forward march can be continued. Canada is still a young country and as such retains a pioneering spirit. Canadian nurses have shown that they possess this spirit in full measure. Pioneering is needed if professional nursing is to meet its new obligations. Presenting the problems may be the role of the *Journal*, but the solutions must be sought and found by nurses in the schools of nursing, hospitals, universities and in the community itself, for this is not the responsibility of any one individual or group. The process could be shortened considerably, however, by sharing the results of trials and errors, successes and failures. In a country of twelve million people scattered widely over nine provinces, it is obviously impossible to arrange for actual personal sharing of experiences. The pages of *The Canadian Nurse* provide an excellent means of communication, but only in proportion to the number of nurses who contribute to or read the *Journal*. When every nurse in Canada is in that category, the matter of solving our problems will indeed be a simpler one.

MARY S. MATHEWSON,
Chairman,
Editorial Board, C.N.A.

The Spastic Child

Ross M. Campbell, M.D.

The title of this paper as given above is actually a popular misnomer used by the public to describe the unfortunate child who is suffering from the condition more scientifically labelled Infantile Cerebral Palsy.

To the parents and relatives of these children and to the devoted workers whose labors in the children's interests have for so long been hampered by the public, and, it must be admitted, professional apathy, the more or less newly-awakened popular consciousness of their problems must appear as the beginning of the fulfilment of many hopes and prayers.

Unlike infantile paralysis or poliomyelitis victims who suffer also from a disturbance of motor function, these children have had, up to the present, no National Foundations and subscriptions to create and support treatment centres. It is not even possible, at the time of writing, to quote accurate figures as to the number of those afflicted. It has been estimated by qualified persons that in the United States in 1942, there were between forty and fifty thousand cases under the age of twenty-one years. Using this as a basis, a rough estimate for Canada would run around three thousand, and British Columbia about two hundred. This is not an inconsiderable number. However, the advisable course to pursue would be by enquiry from all agencies or by survey to reasonably ascertain the number in this province.

Causes

What is the cause of this condition? There is no one specific cause; rather, there are many. Heredity may be dismissed with the statement that in some rare cases it appears to be the sole cause.

Maldevelopment of the fetus, possibly due to the disturbance of its oxygen supply, which in turn causes degeneration of essential brain cells, is a likely cause. It is also thought that if the mother has deep x-ray therapy to the abdomen during her pregnancy, there is some risk of retardation of brain development due to injury inflicted by the rays on brain tissue. This has no relation, of course, to the taking of routine x-ray films. Under maldevelopment we might also list a group wherein embryologic errors occur—whims of nature as it were. It is not too unbelievable that Nature, which puts together the most intricate jigsaw puzzle imaginable, the human body, should slip up occasionally and leave a piece out.

Perhaps the most important cause of all, however, is that which has been broadly labelled "Birth Injuries", a not too satisfactory term because it implies trauma and this is not necessarily involved. Under this heading we may have a restriction or shutting off of the oxygen supply caused by kinking or twisting of the umbilical cord or to premature separation of the placenta. Pressure on the head as it is forced down the birth canal or the use of instruments may also result in a decreased oxygen supply and the results of this have been discussed. At the time of delivery, there may be a tearing of the delicate membranes of the brain or perhaps hemorrhage into the brain with destruction of the important motor control areas, due either to actual pressure or to the fact that the blood vessel has been torn and the blood supply removed.

So far, we have discussed the prenatal and the natal causes. There is one more group—the post-natal. In this are included such things as hemorrhagic disease, severe systemic infection, collapse of the lung, and some others.

The largest group of cases, however, would appear to fall into the natal class. Dr. Olga Bridgeman, of the University of California, investigated

the histories of one hundred and thirteen cerebral palsied children. She found that prolonged labors, instrument deliveries, premature births, and abnormal position at the time of delivery were of far more frequent occurrence in these children than in normal children. Another very interesting finding was that half of the so-called spastics were first-born.

Effects

The effects of these causes depend naturally on the area and amount of the brain affected. In some, the effect is slight, involving perhaps only part of a limb. In others, there is a major damage to the whole brain. The first group rarely needs our help and the second is hopeless. Our main concern, therefore, is with the intermediate group of varying severity, falling between these two extremes. There may be involvement of most or all of one limb, a condition called *monoplegia*, and comprising only a few cases. More frequently one side of the body is involved, to which we give the name *hemiplegia*. Then there are those severe but assistable cases comprising a fairly large group where all four limbs are affected to some degree. This condition we call *quadriplegia*. Where the disability is confined to the legs alone, the state known as *paraplegia*, there is a strong likelihood that the child has had a spinal cord injury and thus does not represent a true cerebral palsy.

The outward signs of this condition —please note that it is incorrect to call it a disease—are many. In the great majority of cases, due to the fact that the baby's nervous system is rather incomplete during its first year, an accurate diagnosis cannot be made for certain until it has reached the age where co-ordination of muscle activity, as in attempting to walk, goes into effect. A few cases will show rigidity of the limbs right after birth. Diagnosis of these is easy but the outlook is not hopeful. The time element in this first year is of no great moment so far as initiation of treatment is concerned.

Some will show *flaccidity* of muscles. This may result where only a small area of the cortex, or outer layer of brain, is involved. *Spasticity*, the dramatic manifestation which has given its name to the overall classification of this condition, occurs when a wide area of cortex is damaged. The muscles are springy and tonic and go into spasm very easily. The flexor muscles of the arms and legs exert a greater pull than the extensors which is why flexion deformities or contractures occur at the elbows, wrists, knees, and ankles. The muscles on the inner side of the thigh are more powerful than those on the outer side so that when the child attempts to walk, the legs cross, producing a scissors gait. When the pull of opposing muscle groups is essentially the same, rigidity of the limbs ensues.

Some children are *ataxic*, that is they show clumsiness due to incoordination of muscle activity. This results in the staggering or drunken type of gait, inability to perform fine movements with the fingers and hands, slurring of speech and tremor. The term *athetosis*, or "mobile spasm," is used to describe the state where the muscles have a thick, putty-like rigidity as opposed to the spastic type. The limbs assume bizarre shapes, facial grimaces are common, and there may be a continual slow change of position of fingers and toes. The athetoid child has better control of his muscular movements when his emotions are not exerting too strong an influence. When his mind is occupied and attracted away from his muscles, the goal of treatment, he may perform quite complicated acts skilfully. When his brain receives too many sensory stimuli from his environment, it is unable to sort them out and attempts to respond to all of them, thus creating confusion of purpose.

In addition to the motor disturbances which manifest themselves in three main ways, as described above, but which can also be present in combinations thus complicating the picture, there are sensory manifestations. The child may be deaf, he

may suffer from disturbed vision, and there may be difficulty in recognizing and appreciating form. The lack of ability to co-ordinate muscle groups is not confined to the limbs. The muscles of the neck and head may be affected, producing slurring speech or *dysarthria*.

The mentality of these children is a favorite and apparently intriguing topic of discussion among the general public. They are not all bright nor are they all mentally deficient. The truth is that it is very difficult to estimate their intelligence in many instances and a decision can only be arrived at after close and prolonged observation by trained personnel. In Dr. Bridgeman's series, the children ranged in age from about one to fifteen years. They were studied at the children's psychological clinic at the University of California over a period of approximately five years. She found that 60 per cent were feebleminded, that is with an intelligence quotient under seventy. Twelve per cent were of normal or superior intelligence and the remaining 28 per cent were in the retarded class ranging from just above feeblemindedness to almost normal. It is significant, she feels, that the normal and superior children were all in the younger age groups and she thought it reasonable to assume that some of these would fail to maintain their higher level. Other investigators have demonstrated variations in these figures but it can be assumed that a fairly large proportion will fall into the retarded and feebleminded class. This factor must be borne in mind when consideration is given to treatment. It has been said that complete competence in a competitive world is extremely rare and false optimism on the part of interested workers is cruel to both parents and child. Undue pessimism, of course, is just as bad, being very detrimental to the success of treatment which will now be discussed.

Treatment

It would perhaps be wise to open the discussion of this section by reminding the reader that there is no easy or set pattern of treatment. The road is hard, long, and devious and requires the utmost patience and perseverance on the part of both the child and his aides. Treatment is adjusted to the child's mentality and to his particular manifestations of cerebral palsy. Because these items are variable and frequently changing, there is a constant need for study of the individual and re-adjustment of the training program.

We may list treatment under the following main headings: (1) physiotherapy; (2) surgery; (3) drug therapy; (4) academic training. Of these, physiotherapy, surgery, and academic training are the most important. *Drug therapy* to date has proved to be of little value except in the control of convulsions and epileptic seizures. Dr. Bridgeman found that 28 per cent of her cases were epileptics, and convulsions were quite common. Sedative drugs produce drowsiness and the decreased mental activity makes the patient less responsive to treatment. Snake venom, bee venom, and the South American Indian drug, *curare*, have been used to induce muscle relaxation but their effect is temporary and they are highly toxic and often dangerous. *Curare*, however, is still the subject of investigation and research and improved methods of controlling its purity, potency, and toxicity may be developed. If so, it may become a useful adjunct to treatment.

Physiotherapy is directed towards re-education of muscles, training in relaxation of opposing muscle groups, the development of musculature, and the overcoming of contractures as far as possible. By teaching correct and simplified ways of performing actions requiring co-ordination, a minimum of muscular energy is expended. The trained physiotherapist engaged in this work will have reason to call on all of his or her knowledge, resourcefulness, and patience to attain the objective.

Surgery is of value more particularly in the case where spasticity is the predominating factor. It is of little assistance to the ataxic or the atheto-

tic child. Many operations have been tried in an effort to reduce or eliminate the flood of undesirable nerve impulses. One of these consists of partial nerve section in cases where over-action of isolated muscle groups is disabling. Nerve section might be used, for example, to overcome the powerful pull of the muscles on the inner side of the thigh thus assisting the child to walk without his legs crossing.

Operations on the brain itself are of no use, on the whole, except to relieve convulsions when these are present, and in a few other selected cases decided upon by the attending surgeon. There is no operation that can be directed at the removal or alteration of the causative lesion.

Considerable assistance may be rendered by orthopedic corrections, such as lengthening tendons to relieve contractures, stabilization of joints, which is done frequently in the ankle to improve walking ability, transplantation of tendons and other operations dictated by the particular problem presented. Operations on the upper extremities are rarely done in cases exhibiting gross mental deficiency. However, operations on the lower extremities may be performed even on feebleminded patients if by so doing they might be helped to walk either alone or with assistance.

The operative results in those patients exhibiting quadriplegia are not as good as in the other groups.

The surgeon may also devise braces and splints to be used alone or in conjunction with operative procedures. However, whether prescribing operation, braces, physiotherapy, or education, the main point to be kept in mind is that the treatment must be made to fit the peculiar requirements of the particular patient and not vice versa.

We come now to the last but in some ways the most important part of the treatment, to wit, *academic training*. This aspect has been often neglected and yet one authority, Dr. Earl Carlson, of New York, himself a childhood sufferer from the condition under discussion, states that the mental growth brought about by education can be the most important factor in the amelioration of the cerebral palsied person.

Education along normal lines is contingent, of course, upon the ability of the individual to be educated. This fact is self-evident and need scarcely be mentioned. The retarded or the feebleminded child, of which there are many in this group, has very limited intellectual powers and this, in turn, limits the value of surgical, physical, and academic measures.

The other children, with normal or near-normal intelligence, can absorb education in the ordinary manner and, as they do, the unaffected centres of the brain develop so that their influence over the damaged controls becomes more effective. There is improvement in speech and there are fewer purposeless movements of the limbs. By enabling the child to exert a greater control over his emotions, the bad effects of fear, anxiety, and self-consciousness are reduced. By developing his ability to concentrate he is able to will his undisciplined muscles to work more satisfactorily. Speech training is often assisted by using a microphone and loud speaker. This allows the child to make himself heard with the expenditure of a minimum of effort and it is evident that the less effort required in the performance of an act, the greater is the control over the muscles. Another aid to the development of articulate and easy speech is instruction of lip reading. By concentrating on the addressee's lips, the number of distracting, external stimuli is reduced and he is able to concentrate on what he is doing.

One cannot close this discussion on academic training without referring to the inestimable effect on the child's awareness that he, like other normal children of his age, is learning to read, to write, and to expand his knowledge of the fascinating world about him. He may not be able to play baseball like the little boy next door but there is tremendous inner satisfaction, with the accompanying beneficial results, in the knowledge that he is ahead of

him in arithmetic. Lethargy, the ever-present enemy in the path of all who attempt to assist the invalid, has been vanquished or at least temporarily routed.

I have attempted to interpret, in as clear and simple a manner as possible, the nature of the condition afflicting the cerebral palsied child. I have touched briefly upon the treatment now in use and some of the difficulties encountered in its application. In closing, may I leave this thought with you. These unfortunate children, deserving of our deepest sympathy and assistance, can in a great many instances be helped but there is no stereotyped routine treatment. The individual case must be assessed repeatedly from the inception of its handling and this involves the closest co-operation between the affected child and its parents on the one hand, and the doctor in general charge, the orthopedic surgeon, the psychologist, the physiotherapist, and the academic instructor on the other. Working together, they can secure the maximum results from the complicated and formidable methods devised for the treatment of these children.

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The Care of Cerebral Palsy

DOROTHY LONGLEY

THE CRIPPLED CHILDREN'S HOSPITAL is a modern forty-five bed hospital, situated in South Vancouver, overlooking the Fraser River. Of the five hundred patients on our files, seventy-three have been diagnosed as cerebral palsy cases. These cases are referred to the out-patient department by the family physician, public health nurse, or through a social agency. On admission to the clinic, the parents are interviewed by the medical social worker, and a medical and social history of the child is obtained.

The child is first given a complete physical examination at the pediatric clinic, then referred to the orthopedic clinic for further examination and recommendation for treatment. Neurological and psychiatric examinations are also made when necessary. On subsequent visits, the child reports to clinic where progress is noted and, when necessary, further orders for treatment are given. These visits are at stated intervals varying from two weeks to six months.

Approximately two-thirds of this group of cerebral palsy cases are of the milder type, and tend to improve as the child develops physically and mentally, without the benefit of special treatment or with very little treatment. The more severe cases report to clinic once or twice weekly for treatment. Those unable to walk are transported to and from their homes in the hospital car.

In the Department of Physical Medicine, the child is taught the fundamental movements to gain muscular co-ordination. This is accomplished by relaxation exercises and hydrotherapy. It is especially important to obtain relaxation first, because, until this has been accomplished, treatment by way of muscle training is not effective.

Instructions for home training to the parents are of utmost importance. A few exercises, regularly done, do prove beneficial and written instructions are made out for this purpose.

To obtain the best results with

these cases, the nurse and physiotherapist must possess an infinite patience, a calm and deliberate manner of speech and movement. Any trace of irritation or impatience is immediately reflected in the child, and he becomes tense, nervous, and excited.

Due to lack of accommodation, only those patients requiring surgery, or those who live out of the city, are admitted to hospital. The latter group receive daily treatments over a period of one to three months. On discharge from hospital the parents are given instructions to carry on treatment at home.

Some cases with sufficient mental ability to co-operate, and with a sense of balance, can be helped by surgery. Such procedures as neurectomies and tenotomies tend to relieve the contractions of knees and elbows, and section of the muscles in the forearm allow pronation. Surgery is contra-indicated in athetoid cases and where there is lack of balance.

The post-operative nursing care follows the procedure used in orthopedic surgical cases—elevation of the limb, application of ice bags to operative areas, etc. It has been noted that there is a general retrogression following surgery. Therefore, every effort is made to begin physiotherapy treatment as soon as possible, and encourage the child to resume his particular form of normal activity.

The degree of progress in all cases of cerebral palsy depends upon the mental ability of the child to co-operate, his sense of balance, and the degree of athetosis present. Some cases, in time, obtain comparatively good function of the affected parts while others seem to be static, or at best learn to walk only with support.

As hospital patients, these children receive educational training during the regular school hours. For out-patients, the training is somewhat limited. Children with sufficient mental ability receive home instructions by the visiting school teacher.

The following are brief histories of two cases, to illustrate a comparison in the degree of progress:

The diagnosis in the first case was hemiplegia—left side. Seven years ago, Mollie was unable to pronate her arm or hand, or to put her heel to the ground. After several years' treatment and two operations, namely, lengthening of the tendon Achilles and section of the pronator radii teres, the function of both limbs improved to such an extent that Mollie is now able to work successfully as a stenographer.

In the second case, the diagnosis was quadriplegia, with some degree of athetosis, a slight speech defect, and a strabismus. After eight years of treatment, Jack is just beginning to take a few steps, and then only with the support of long leg braces, Taylor brace, and crutches. The speech defect has improved, but becomes evident when he is disturbed.

While progress has been made by the majority of these cases, the lack of greater improvement in the more severe cases has made it evident that our present program is not adequate. Plans are now being formulated to extend this program—to provide the much-needed accommodation and facilities for the treatment of cerebral palsy cases. A station-wagon, to replace the car now in use, is expected to be available by early summer to transport the children to and from the hospital. A new wing is to be added to the present building where these children will be treated as day patients. During the course of their six-hour day at the hospital, they will receive intensive physical training, with some measure of educational and occupational training. In addition, there will be supervised rest and play periods, and instruction given in regard to personal care. Plans have also been made to establish clinics for eye, ear, nose and throat examinations, and for dental care.

In this way, we hope in time to attain a well-rounded developmental program of physical, educational, and occupational training for cerebral palsy cases.

The Public Health Aspect of Cerebral Palsy

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WITHIN RECENT YEARS, there has been an awakening of interest in the problem of cerebral palsy. This condition, known formerly as "Littles' Disease", is now being considered by the medical profession as a subject worthy of more research. Educationalists have come to realize the neglected potentialities of its victims. New and improved methods of teaching the cerebral palsied child are gradually evolving. All this emphasis encourages the determined parents in their belief that not all cerebral palsied children are destined to be labelled as hopeless cripples and idiots. With special training and guidance, rehabilitation to a happier and more useful life now seems possible.

The immensity of this problem is only now being recognized. Reliable estimates have shown that there are seven children born with cerebral palsy in every one hundred thousand of population. Yet we must remember that an accurate analysis of the situation cannot be presented until a more complete system of registration is adopted. With compulsory registration, the numbers and distribution of the cases could be accurately determined. Diagnostic and treatment facilities could then be planned to suit the specific needs of each area.

The current interest in Cerebral Palsy has revealed many inadequacies in the existing resources. In California, the Alameda Spastic Children's Society has provided a graphic illustration of what can be done. It has sponsored a cottage hospital, situated on the grounds of the East Bay, in Oakland. Here, fourteen children between the ages of three and six years receive the benefit of a well-co-ordinated program. The Children's Hospital supplies ready facilities for surgical and physiotherapy treatments. The cottage school provides academic education, with special emphasis upon muscle training, speech training, and group adjustments. The weekly attendance of the parents ensures a close co-operation between the home and the school. The Alameda Society is, however, an isolated example. Only twenty-seven of the forty-eight United States have developed even limited programs for the care of cerebral palsied children.

Canada, too, has little to offer her cerebral palsied children. The varied programs developed for crippled children have included the spastic child, but lack of knowledge and interest have hindered the full development of these programs. Perhaps the soundest foundation for growth has been laid by the Ontario Society for Crippled Children. This organization is aiming toward complete supervision of all crippled children in the province. Doctor, public health nurse, or parent may refer a child for diagnosis and treatment to any of the orthopedic centres situated throughout Ontario. When the child returns home, supervision is given by the local public health nurse, under direction of the orthopedic consultant from the Society. In the summer, the Society sponsors the Blue Mountain Camp for crippled children, situated on the shores of Georgian Bay. The isolated cerebral palsied children who are able to attend, show, after three weeks of camp experience, marked improvement, not only in physical skills, but also in social behavior.

The City of Toronto has partially solved the question of the education of its handicapped children with the establishment of special classes at Wellesly School. Approximately half of the seventy-eight children attending these classes are cerebral palsied cases. Each child is enrolled only

after a careful investigation of his physical and mental ability. A well-balanced curriculum offers not only academic training but also corrective exercises, speech training, and occupational therapy. Transportation to and from the school is provided by the Toronto Board of Education.

At the present time, there are only limited facilities available for the treatment of the cerebral palsied child in British Columbia. These centre around the Crippled Children's Hospital in Vancouver, and Queen Alexandra Solarium for Crippled Children at Cobble Hill, Vancouver Island. Here diagnostic and therapeutic services are provided for the scattered population of the entire province. The fact that it is possible to offer only an hour of physiotherapy treatments to the out-patients once a week demonstrates clearly the need for further expansion of this resource.

The education of these handicapped children in British Columbia is secured for the most part by correspondence courses from the Provincial Government. In urban centres, special instruction may be obtained through special classes in the schools or visiting teachers. In Vancouver, there are only two such teachers employed by the School Board to carry out home instruction for the entire metropolitan area. One local investigator, John E. Sparks, has studied the educational problem of cerebral palsied children of school age in Vancouver. Out of eighty-five cerebral palsied children of school age, only nineteen were found to be receiving any type of academic training. Only seven cerebral palsied children were attending the special classes of the city. Such an investigation demonstrates the pressing need for more educational opportunities for these handicapped children.

Through the activities of the newly-organized Spastic Society of British Columbia, considerable attention has been focussed on the subject of cerebral palsy. This group is aiming toward the provision of more adequate treatment and educational facilities for cerebral palsied children throughout the province. Already it has secured considerable financial support from service clubs, private organizations, and interested individuals. Undoubtedly, many of the future advances in the field of cerebral palsy may be traced back to the instigating efforts of this ambitious organization.

The years to come will naturally bring about many changes in our present-day concepts of cerebral palsy. No doubt, a more revealing picture of the problem will be presented when a system of registration is adopted. All birth injuries and congenital malformations should be reported as soon as diagnosed. Intelligent plans can be made when an accurate distribution of cases is known.

Although a variety of programs have been formulated for the treatment of cerebral palsy, the present trend is towards the establishment of a combined program of physical training and academic education. The cottage school at Alameda exemplifies such a plan. In the cottage school, medical care is carefully integrated with the academic work. A close relationship is fostered also between the home and the school, in order to accomplish a correct interpretation of the entire program. Such a centre could be used not only as a day school, but also as a residence for the children of isolated areas. Research activities and the training of professional personnel would be developed around the cottage project.

Rural areas could be served by the establishment of small permanent or travelling field clinics. Such centres would act as diagnostic and referral agencies. As travelling clinics, a group of trained workers would visit the small towns and isolated districts to interview and advise regarding treatment for the cerebral palsied child.

For some cases, the cottage school type of treatment would be considered unnecessary. Special classes in existing schools would be sufficient to answer the needs of those children who are physically and mentally able to attend regular classes. Nevertheless, even these children require

individual attention, stressing group adjustment and physical therapy.

In addition, approximately 30 per cent of all cerebral palsied children require custodial care because of limited mental capacity. The presence of these children in the home means not only a heavy burden to the parents, but also a dangerous threat to normal family relationships.

It seems logical to assume that one of the key persons in any adequate cerebral palsy program is the public health nurse. She is the link between the home and the community health facilities. Through apathy and ignorance, however, the public health nurse has been too willing to accept the common belief that the cerebral palsied individual can be nothing but a hopeless cripple. Yet, with an adequate and enlightened presentation of the condition, she will become conscious of her part in the program. Once on the alert for cerebral palsy, the public health nurse will be watching in the child health centre and the school for early signs of this condition. The infant who displays an inability to grasp objects, to hold up the head or to stand, and the child who shows a peculiar walk, such as continuous toe walking, or a scissors gait, will be referred by her to the nearest diagnostic centre for further investigation.

In addition to her case-finding role, the public health nurse will act as an interpreter of clinic recommendations to the family. She will offer general health supervision, stressing nutritional needs, habit training, and normal family relationships. She will give specific advice regarding clothing. With emphasis upon the principle of self-help, the parents will be encouraged to provide suitable clothing, stressing large buttonholes, zippers, pullover sweaters and suspenders, since they help to eliminate some of the dressing hazards for the cerebral palsied individual.

Undoubtedly, within the next few years scattered parent groups, patterned after the Spastic Society of British Columbia, will develop throughout Canada. To these organizations the public health nurse can contribute much from her background of knowledge and experience. It will be for her to give active support to, to encourage, and to promote these worthwhile activities wherever possible.

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The Society of Registered Male Nurses in Britain is offering a prize to the male nurse who submits the best list of equivalent titles for men in all grades of hospital nursing from student nurse to matron.

Accounting for Nurses

PERCY WARD

PART II

WE HAVE PREVIOUSLY discussed balance sheets; revenue and expenditure statements, and receipt and disbursement statements; and how to read them. Let us now discuss the detail records from which these statements are compiled.

These statements are finished articles produced for use. They are made from raw materials which have to go through a number of processes. The raw materials of accounting are those events which directly concern the economic progress of the hospital. These events are very numerous, in fact, sometimes they occur so rapidly and in such quantity at one time as to make it difficult to find the time to record them immediately.

These events include all admissions and discharges of patients; the amount of money the patients owe to the hospital; the amount they pay; the quantity and price of goods and services the hospital buys; the amounts owing to others; the amounts paid to others; the value of donations, whether in money or in kind, and many others.

There are three major stages through which records of these events must pass. These stages are: (1) the original entry; (2) listing the events in order of time; and (3) re-sorting the items into appropriate and comparable classifications. These three stages may appropriately be called: (1) original entries; (2) intermediary books; and (3) ledgers.

Original entries may take any one of a number of different forms, depending upon circumstances. Intermediary books take the form of sales books or, in hospitals, patients charge books; cash books and journals. A ledger is a book, or a series of books, that may be likened to a letter-sorting box, each ledger account being a pigeon-hole into which like things are sorted.

In accounting it is necessary to remember that bookkeepers are human beings, and that all human beings make mistakes. As some mistakes may have very serious consequences, it is necessary to introduce a device which will bring to light any mistakes that have been made, so that they may be corrected. This device in bookkeeping consists of entering figures in two different ways so that the sum of the one will agree with the sum of the other; that is, so that they will balance.

ORIGINAL ENTRIES

Let us now discuss some important principles concerning our first classification, i.e., primary entries. The recording of primary entries should be so arranged that it is possible to make the primary entry at the time the event occurs. This means that the materials upon which primary entries are recorded should be easily and quickly available. In other words, it is usually unwise to try to make original entries directly into bound books, because the particular book is often not readily available. Even if the particular book should happen to be sometimes immediately available, hurried entries in bound books mean undecipherable scribbled entries which invite mistakes.

Primary entries are intended to record events which are likely to be forgotten if not recorded at once. These consist of admitting the patient; receiving money; paying out money, and recording gifts or income in kind. The best type of admission form consists of a form printed on paper and put up in pads so that, when a patient arrives, the nurse can have a pad handy and can fill in the name. Once the name has been entered, the nurse, if in a hurry, can leave the completion of the form until some more convenient time, without danger of forgetting to report the admission. There should be numbered receipts in dupli-

cate with a carbon paper between so that the original may be given to the payer while the duplicate remains on record. Money should never be paid out except by cheque. If petty cash is needed, this should first be drawn by cheque from the bank and later disbursed in cash, and accounted for.

Please keep in mind that a receipt book and a cheque book are not strictly "books" in the sense referred to herein. Each of these consists of separate forms padded together. A padded voucher form should be kept handy upon which to record transactions which do not involve the receiving or paying out of money, e.g., for receiving gifts or payments in kind, or for recording the receipt of goods unaccompanied by delivery slips or by an account.

Once the foregoing primary entries are made, or partially made in the case of the admission of a patient, the event does not have to be carried in the memory. The primary entries ensure that all necessary subsequent entries will follow automatically.

To summarize the main points concerning primary entries, it is essential that important events be not forgotten. It is also important that the employee's mind should be upon what he or she is doing, and should not be cluttered with events that have to be carried in the memory. Events will often be forgotten if they are not written down at the time they happen. They are not likely to be written down at once if it is necessary to go searching for a bound book. Pads or forms can be kept in several strategic places.

Intermediary Books

Intermediary books are those into which events are recorded, in order of time, from the original primary entry forms. In a hospital, these intermediary books consist of a hospital register or charge book, a cash book, a journal, and a voucher register.

Patients' admission forms are entered in the register, from which the patient's number is obtained. The duplicate receipts are entered in the cash book, and so are the cheques, but on opposite sides. Vouchers, and all accounts payable, are entered into the voucher register. A journal is a book used for recording receipts in kind, and for recording inter-departmental transfers. Cash transactions (including cheques) should be entered in a cash book only. Under no circumstances should a cash transaction be entered in the journal.

There are many variations and combinations of cash books, journals, and voucher registers, e.g., many small hospitals keep a separate book for cash receipts only, so that it may contain a number of columns which enable the keeping of records showing what each receipt is for. It is a common practice in many small hospitals to combine a voucher register with the disbursement or outgoing half of the cash book, so that each account payable can be compared easily with the amount of money paid in respect of that particular account.

In summary, intermediary books are really lists of primary entries; but these lists are bound together in book form. There are separate lists for charges against patients, for cash, for goods in kind that are received or given out, and for tradesmen's accounts payable.

Ledgers

Ledgers are the books that classify all the events that were recorded as primary entries and were later entered into the lists which constitute the intermediary books. Classification of ledger accounts varies widely in different enterprises. In hospitals, it is necessary to have in the ledger, a bank account; an account for charges against and receipts from patients; an account for grants and donations; an account to keep records of the money that is owed to others; an account to record expenditures, and a surplus account. The foregoing is a bare skeleton outline. Other accounts are necessary, depending upon each hospital and what it does.

Entries are made into the ledger account from the intermediary books. This process is known as "posting." Receipts of cash are totalled in the cash book and the total is put into the ledger bank account. Again, the

cheques issued are totalled, and the total is put into the bank account on the opposite side from the receipts. The difference between the two, plus the balance brought forward from the previous month, shows how much money there is left in the bank, assuming that all cheques issued have been cashed.

The total of the patients register or charge book is put in the ledger account concerning patients and, on the opposite side of the same account, is entered, from the cash book, the amount received from all patients. The difference between the two indicates the amount owed by all patients.

The total of the voucher register is entered into the expenditure account in the ledger. Under the expenditure account in the ledger is kept a subsidiary ledger account known as a "cost" book. In this book is kept a record of how much of the purchases has been consumed in a given period—usually one month. This book shows the value of the quantity consumed. The difference between the amount purchased and the amount consumed shows the value of the expendable material still on hand.

There are many forms of ledgers, including control and subsidiary ledgers. A control ledger account contains the total of one general class, while a subsidiary ledger contains sub-divisions of the general control account, e.g., a patients' accounts receivable control account should contain one balance figure showing how much is owed to the hospital by all patients and ex-patients. The individual patient's accounts constitute the subsidiary accounts under the control. If the balances owing by all individual patients were added together, the total should agree with the balance of the patients' accounts receivable control account.

To keep records properly, first make sure that nothing is overlooked; then list what has been recorded; then classify all entries so that like things may be compared with other like things. The results will indicate what is happening economically and whether present procedures are likely to lead away from financial difficulty, or into it.

(To be concluded in the July issue)

Speech Clinic at the Children's Memorial Hospital

MARY B. CARDOZO, M.A.

THE MAIN PURPOSE of the Speech Clinic is to attempt to make able in speech those who are not able and of re-training those whose speech habits are defective or of devising ways and means of offsetting the effects of various maladies that disturb speech or prevent its development.

By speech, we mean a form of language which man uses without resorting to outside agencies. The chief elements are: voice, action, and articulated sound. The last element differentiates man from lower forms of animals. Only man is capable of this differentiation which we recognize as words and which, when organized, is spoken language.

We then may ask what is defective speech? For our purposes, we say the speech of a given patient may be regarded as defective when any one or all of the following factors appear:

1. It is unintelligible, inaudible or confusing to the listener.
2. It draws adverse attention to itself because of its conspicuousness.
3. It is unpleasant to hear or is accompanied by unpleasant extraneous sounds or movements.
4. Its production is labored and difficult

and lacks general smoothness of rhythm.

5. It is inappropriate to the age of the patient or the child, in type, amount, or degree of development.

The terms, disorder and defect, should now be defined rather than used casually. The latter considers only the end acoustic result or what you hear. The former is more comprehensive and takes into account the underlying condition causing it. All speech disorders exhibit defects, but not all defects disorders. When we have a disorder and the disturbing factor is a pathological condition, the treatment, correction, and re-education of the speech follows or complements the work of the physician responsible. When the disturbing factor is a reparable, congenital, structural deformity such as a cleft palate, the work of the speech clinician begins where the work of the surgeon stops.

An accurate classification of speech defects is not possible in a strict sense as no speech difficulty is either completely organic or entirely functional in its origin. In general, we may say that if a disturbance in speech is never exhibited unless associated with a physical defect, such as spasms of nervous origin or a defect of the speech mechanism itself, we consider the disturbance basically organic. If the defect is associated with difficulties which are basically emotional, and if the difficulty shows marked fluctuations in severity which are concurrent with emotional rather than physical disturbances, the problem may be considered to be fundamentally psychogenic or functional. In all cases, the speech clinician is likely to employ psychotherapy and organic re-training.

Before going further, it may be well to stop and review some of the findings on the incidence and distribution of speech defects in the United States. In 1931, the White House Conference Report, which was a nation-wide survey of children between the ages of 5 and 18 years, indicated that there were one million school children so defective in their ability to speak as to be in need of remedial treatment and training. In one large city alone, fifty thousand were found or 5 per cent of the school population. The types of speech defects were classified. These are the same classifications used in the C.M.H. clinic:

1. Stuttering.

2. Oral inactivity—the articulators are under-active.

3. Sound substitutions—or delayed speech. By the time a child is four years old, or ready for education, the speech should be clear and easy to understand. If there is a persistence of early baby patterns, it should be a real concern to the parents and teacher.

4. Post-operative cleft palate. In this case, re-training is absolutely necessary or previous indistinct patterns will persist.

5. Voice problems, both structural and functional, such as hoarseness.

6. Paralysis, particularly of the spastic type.

7. Dysphasias and aphasias—sound perception and association.

8. Speech of the hard of hearing and the deaf. The writer, in accordance with modern educational methods for the deaf, does not believe in the teaching of signs but rather, with the aid of an otologist, seeks precision testing to find residual vestiges of hearing which when fitted with a proper hearing aid can be used to teach language. It is the more difficult method but, in the long view of the child's adjustment, more satisfactory.

It is undoubtedly wise to begin speech education as soon and as early as possible, especially before the child begins to realize that he differs from other children and fortifies himself with unhealthy psychological attitudes and emotional blocks which hinder education and development. In all cases without special teaching or re-education, the prospects of improvement are rather gloomy. *Children do not outgrow speech defects.* When a child is referred to the speech clinic, the first task is to study the symptoms of the disorder and attempt to trace them back to their ultimate etiology. Each case is unique and must be treated as such. Approaching the whole child, his behavior, his re-action to his environment or, in other words, his total personality

picture must be studied. Treating the end result, the defect, is not enough. First, we must gather a personal and family history with relevant psychological facts. This includes family problems, sibling relationships, the child's re-action to the family, social position, and environment. The intelligence should be determined by the standardized scale, for this indicates to us how far we will be able to go and may indicate the causal factor for which we are searching. Then we must, with the aid of the physician, determine the health history, that is the present state of health, the onset of walking, diseases, accidents, unusual events, a study of the hearing of the child. Speech history would include conditions under which a child learned to talk. The maturation of speech, abnormalities of the mechanism, the description of phonetic change, and the present methods of communication are all noted. Only after this information has been gathered can a true diagnosis be made and therapeutic measures be taken.

In many cases, such as in a child with cerebral palsy, the speech will never be absolutely normal but enough improvement is made that the child will not be conspicuous to the lay person. This alone would justify the expenditure of time and energy. Much-needed encouragement and understanding is given to help the patient in his own attitude towards his defect. In other problems, we strive for near perfection.

During the past year, there were 977 patient visits to the outdoor speech clinic at the Children's Memorial Hospital. Of this number about half were of school age. It is generally wiser to begin the training early as, when a child reaches the educational age and associates with other school children, his defect marks him as being different and this factor may be the cause of a serious educational maladjustment. It is his right to enter this important phase of his life with the tools which are his birthright.

About that Article Contest!

The months have a way of slipping along so quickly that we are now almost up to the date that was originally set for the deadline in the 1946 article competition. Realizing how very busy every nurse has been this past spring with staff shortages still a pressing problem, it has been decided to extend the closing date until **October 1, 1946.** This change will permit many nurses, who have been too tired to write after an exhausting day's work, an opportunity to complete their entries.

Have you forgotten the details of the announcement which appeared in our February issue? Let us refresh your memory. Two separate topics were selected from suggestions that were received. For each of these, two prizes will be awarded—first, $25; second, $15. Every nurse is eligible as a competitor. It would be quite in order for a nurse who felt she had a good story to tell regarding the importance of bedside nursing to also submit an article on the second topic. Purposely, no specific word limit was set this year as some of the competitors in the 1945 contest felt themselves hampered by a word limitation. Our only comment is—don't try to write a book length article.

The bases for judging the entries which are submitted will be:
Soundness of opinions expressed.
Originality of ideas.
Clarity of thought.
Pertinence of any suggestions.
Ultimate value to nursing.

In case you missed them the first time we repeat the topics upon which you may write:

1. Bedside nursing—an essential service.

2. The integration of classroom and clinical teaching.

Remember the deadline — **October 1, 1946!** Let us have your entry soon. Mark the envelope "1946 Contest." All articles become the property of *The Canadian Nurse* and the prize winners will be announced in plenty of time to enable those lucky nurses to spend their money for Christmas.

Contributed by Hospital and School of Nursing Section of the C. N. A.

One Answer to the Weekly Headache

ANNE M. CARPENTER

THE HEADACHE: planning a logical time-table with provision for correlation of subjects taught.

The answer: a graphic weekly program board.

It began two years ago when suddenly we found ourselves, a group of instructors, forming an entirely new teaching staff in a school of nursing. Each of us was coming to her position either directly from university, with all her principles and ideas as yet shining new and untested, or from a smaller school of nursing where, with only one instructor involved, the formation of a satisfactory and correlated weekly schedule was no great problem. Naturally, uppermost in our minds were the questions: How can we fit the various lectures into each day's hours to best advantage for the learning content? How will we be able to know what the other instructors are teaching so as to correlate effectively and to avoid overlapping? How are we going to unify the emphasis in our teaching so that it permeates each course in the program? How can we best share our problems and make the inevitable adjustments with the least possible disturbance to the general plan?

Our first answer to the problem was rather gauche and unhandy but it worked for a while. At weekly instructors' meetings we used a mimeographed worksheet with spaces for each class-hour of the week's days, along with columns for the hour's class and class content. At the beginning of the meeting each instructor briefly described the content of her classes for the next week, and discussion naturally evolved as to points of correlation, emphasis, and so on. Similarly such discussions and planning stimulated the sharing of problems in student guidance, the use of teaching facilities, the adjustment of discrepancies discovered in nursing technique on the wards, etc.

Using these worksheets, the in-

Weekly Program Board

structor went back to her office at the end of the hour's meeting with a concrete outline of the program of instruction for the coming week. At the end of a preliminary period, she possessed an exact record of this period's program content, with adjustments that perforce had been made and with the correlation that had been achieved. This was a substantial aid in the introduction of improvements in her plan before the course was offered again.

A similar procedure was followed by instructors participating in the integrated course of lectures in the junior period, including medical nursing, surgical nursing, diet therapy, pharmacology, and health teaching applied.

Eventually a much better suggestion was put forth by someone with an eye for graphic illustration. This was a schedule board on which was planned the entire teaching program, with small cards on which were written the contents of each week's lectures in every subject offered. The physical set-up of the board can be seen in the accompanying illustration. Black cotton tape guiders enabled the instructor to remove and re-insert her cards readily so that adjustments could be made in the course content. Each instructor can go to the board at any time to check over her course's correlation with the entire program. Now our conferences are held around such a board and a much clearer picture of the situation as a whole is received.

Through this method of experimentation and correlation each instructor has been able to crystallize a stable pattern for her course. Yet the main advantage has been found to fall to the person responsible for planning the weekly time-table. Using this method she is quickly informed of changes in any instructor's course content, and before each week from the cards of lecture content she can readily see how to arrange the sequence of classes for each day—what should come before what; which classes are best given at 9 a.m.; and which can be "tolerated" at 1 p.m.—for those classes which are not always given at the same hour each week.

We have liked our weekly program board.

Red Cross Scholarships in Manitoba

The Manitoba Division of the Canadian Red Cross Society offers a scholarship of $600, to be given each year for three years to nurses registered in the province who wish to take post-graduate courses in public health nursing at the University of Manitoba.

Essential Qualifications

1. The candidate must produce a letter from the director of the School of Nursing Education that she has met the requirements of the University for admission to the course in public health nursing.
2. She must give proof of personal aptitude for community service.
3. She must have at least a Grade XI standing with an average of 60 per cent.
4. She must be willing to sign a contract to serve under salary in the public health field in a rural community for a period of two years immediately following her graduation from the University.

The Manitoba Division of the Red Cross has asked the Bursary Award Committee of the Manitoba Association of Registered Nurses to recommend the candidate who will receive the scholarship.

For further information apply to: Commissioner R. N. Snyder, Manitoba Division, Canadian Red Cross Society, 31 Kennedy St., Winnipeg.

Preview

We are fortunate in having secured a word picture of nursing conditions in Belgium, both during the war and since, from **Cecile Mechelynck,** who has recently been a guest in our midst. "We never lost hope that we would be liberated, even in the darkest days," said this famous visitor. Don't miss her story!

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Orthopedic Nursing in the Community

GRETTA M. ROSS *and* EDNA L. MOORE

"IF ONLY WE MIGHT have found these children earlier, when we could have done something for them!" This was the keynote of an address by the surgeon following a large orthopedic clinic held recently. These words are both a challenge to nurses and other health workers and a rebuke to organized society.

There are many channels through which information might be secured regarding the whereabouts of infants and young children who are in need of orthopedic services. A space on the physician's birth registration form for recording birth anomalies; better understanding concerning the importance of early and continued treatment on the part of parents and public generally; regularly conducted surveys and the availability of facilities for family medical supervision are a few. Yet given these and other sources of information with adequate diagnostic and treatment facilities, the preventive approach to the problem would be the fundamental consideration.

An adequate community health service with the family as the unit provides the first step in the prevention of crippling conditions. The prenatal period can be singularly productive in this field, while patient and skilful medical and nursing care throughout labour and at delivery are highly important if birth injuries are to disappear from the list of causes of crippling. The supervision of the newborn and the infant by a trained health worker, together with proper daily care, also contribute to prevention. Furthermore, training in child development helps parents to cooperate intelligently with the community health agencies.

A continued educational program is essential to create in the public mind an awareness of the importance of prevention. With the pasteurization of milk, the isolation of tuberculous patients, and the follow-up of contacts, there has been a marked decrease in the incidence of tuberculous infections of the bone, while emphasis on proper nutrition has eliminated to a marked degree the deformities which may follow rickets. It is reasonable to expect that the stress which is now being put upon accident prevention, first aid, and nome nursing will tend toward a reduction in the number of accident deformities. To these efforts should be added the realization that any deviation from the normal demands a medical examination.

What is being done about these handicapped children and young adults in our midst? They are with us—the post-polio paralytic; the victims of cerebral palsy, club foot, unrepaired harelip, congenital dislocation, burn contracture, and many other crippling conditions. Is it because the child is not acutely ill—probably because the family has accepted the disability as an act of

Providence—that public health nurses pass along to what may appear to be a more immediate demand, and thus the years, during which much might be accomplished, pass, leaving handicapped adults for whom so often little, except of a palliative nature, can be done.

The nurse has not only a definite responsibility but an opportunity for stimulating community interest in crippled children work. A survey provides the most practical way to obtain a picture of the community situation. An active survey committee with good publicity—newspaper, radio, movies, talks—may startle a complacent community through the discovery of previously unknown, untreated cases. The nurse must be constantly on the alert in the home, in the child health centre, in the school, and in the life of the community, to find the handicapped child at the earliest possible age, to get him under treatment, and to give adequate supervision following his discharge from hospital.

It is usually necessary to interpret hospital orders to the mother and in many cases to impress upon her from the beginning the importance of the time element. Treatment of orthopedic conditions frequently must continue for months and even years, during which time parents are apt to become discouraged and, therefore, prone to follow the suggestions of well-meaning neighbors. By so doing the good results of months of treatment are often nullified.

Adjustment to a home or school situation following a long period of hospitalization may be difficult. In one home there may be little time for extra attention while in another the child may be overwhelmed with sympathy by an anxious mother. If crying brings attention the infant quickly learns to use his power, and when he reaches his second year or later temper tantrums may be his weapon. Such conduct tolerated by over-anxious parents may warp the child's personality and hinder him in developing initiative along constructive lines.

Throughout nature evidences of compensation are frequently recorded. With the physically handicapped these manifestations are notable and this fact brings into clear relief the importance of mental hygiene in the care of these children if they are to reach the full development of their potential abilities and find satisfaction through a worthwhile contribution to society.

A home-bound child must have education either by means of a visiting teacher or correspondence lessons. He also must have occupation and outside interests and these may be organized by members of service clubs and other societies if sufficient interest is aroused in the community. In the same way other needs of the child such as transportation to and from hospital, clothing, or extra nourishment may be met. In school it may be hard for a teacher to understand that Jimmy, with his severe handicap, wishes to be treated in the same way as the other boys and that laughter is easier to take than pity.

Vocational guidance and placement are often neglected in our plans for the handicapped. Assistance is readily found for the pretty little girl who requires a new brace but the crippled young adult frequently looks in vain for someone to become sufficiently interested to help him find a job.

Healthy recreation, of whatever sort the girl or boy may be able to enjoy, is essential. Obvious pity must not enter into the situation. Sympathy can be shown without words and with one or two real friends the crippled young adult may have courage to face the world and become a self-respecting, self-supporting citizen, taking his place in the life of the community.

Thus as we scan the complete picture of the handicapped in community life two things which stand out are the urgency of finding him early and the long-term objective of prevention. Are public health nurses adequately equipped for this task? Are they as conscious of responsibility regarding the undiagnosed limp as they are of the defective vision or the enlarged tonsils of the child in the home or in

the classroom? If they are not ready for this much needed service, why not? In the curriculum of the basic and graduate courses, is sufficient emphasis being placed upon orthopedic nursing?

In Ontario there is a close relationship between the Division of Public Health Nursing of the Department of Health and the Ontario Society for Crippled Children. By arrangement the public health nurses of the Society's staff visit in a consultant capacity, with public health nurses in the service of municipal and county Boards of Heath. The nursing service of the Ontario Society for Crippled Children consists of four staff nurses and a director and extends over twenty-eight counties of the province. The members of the nursing staff have had special training and experience in orthopedics as well as in generalized public health.

The Society works in close cooperation with the service clubs interested in crippled children work and its nurses act in a liaison capacity between the official health agencies and the service clubs. The clubs are encouraged to undertake annual or biennial case-finding surveys. With the approval of the family physician, cases found through the survey are brought for examination to local special clinics arranged by the Society or to the nearest orthopedic centre.

Local clinics sponsored by service clubs are conducted by an orthopedic surgeon and a neurologist and are usually attended by one or more of the Society's nursing staff. The local public health nurse is present and later she goes with the consultant for the follow-up visit, the result of which is reported to the Survey Committee. This information, together with the recommendations of the clinicians, is recorded in the local public health nursing service and provides the basis for continued supervision.

The consultants arrange for group conferences with the local public health nurses as frequently as possible. The topics discussed include orthopedic conditions and individual cases in the community.

The Ontario Society for Crippled Children owns and operates Blue Mountain Camp for crippled children on the Georgian Bay. There, a holiday is provided for 176 children from various parts of the province. Through this activity the staff members have the opportunity of really getting to know the handicapped child.

The Camp, although designated officially as a convalescent hospital, has little of the hospital atmosphere and many a child has a changed outlook on life at the end of his three-weeks' holiday. He is stimulated by the efforts of others to become more self-reliant. He loses much of his self-consciousness. Pity is an unknown quantity and he has no sense of inferiority for happiness is the keynote at Blue Mountain. As one small boy with a severe handicap remarked as he gazed at his companions on his arrival at Camp, "Gee! I'm lucky—I might have been like Johnny!"

With the recent purchase by the Society of a large estate, "Woodeden", near London, it is hoped that not only a much larger group of children may be given a holiday during the summer but in the winter a residential vocational school may be provided.

One need work with crippled children for a short time only to realize that the field is vast, the need for trained and experienced workers is great, and the desired results will come ultimately through the preventive approach.

Preview

With birth rates abnormally high during the past few years, the problems associated with pregnancy have assumed a new importance. One of the very interesting fields of study has been concerned with the various types of anemia which may be found and their influence on the well-being of the expectant mother. **Dr. J. L. Macarthur** has described the anemias of pregnancy and the postpartum, outlining their treatment and emphasizing the role of extrinsic factors. This useful material will be featured next month.

AUX INFIRMIERES CANADIENNES-FRANÇAISES

Observation sur la Penicillinothérapie

SOEUR A. ROSE, S.G.M., B.S.

DANS SA MARCHE vers le progrès, la médecine avait fait un grand pas en utilisant les sulfamidés, mais combien plus grand encore est celui qu'elle réalise par la découverte de la "pénicilline." "Prodigieuse médication qui sauve et qui sauvera d'innombrables vies humaines et qui dès maintenant transforme la pathologie, l'évolution et le pronostic de multiples infections."*

Avant de parler de ce que nous avons observé au sujet du traitement moderne, jetons un regard rétrospectif sur l'histoire de la Pénicilline.

D'abord elle fut découverte par Sir Alexander Fleming, un écossais, bactériologiste à l'Hôpital St-Mary's de Londres. Ce grand bienfaiteur de l'humanité était justement de passage à Montréal il y a quelques mois et c'est lui-même qui racontait à nos médecins, comment il a fait sa merveilleuse découverte.

C'était en 1929, alors qu'il poursuivait des observations sur les staphylocoques, sur les différentes variations de ces cultures. Pour opérer ses constatations il devait ouvrir fréquemment des boites d'ensemencements. Les milieux étaient contaminés. Fleming observa avec perplexité et surprise que certaines colonies de staphylocoques subissaient une lyse impressionnante. Fleming avait bien vu qu'un champignon avait contaminé son milieu de culture et il se rendit compte que la lyse des staphylocoques était due à l'action de la moisissure. Et c'est là son mérite d'avoir saisi ce phénomène apparemment banal et d'en avoir poursuivi les rapports et les conséquences.

La moisissure était le *Pénicillium notatum.* Il en retira après culture le principe actif qu'il nomma "Pénicilline." Il entreprit dès lors l'application dans la lutte contre les infections microbiennes. Bactériologiste limité dans les moyens de préparation et de purification d'une Pénicilline adaptable à la thérapeutique pratique, il ne se contenta que d'en prédire l'usage merveilleux. Là se termina son oeuvre. Fleming avait ouvert la voie vers la prodigieuse médication qui sauve tant de vies.

Il fut ensuite donné à l'équipe d'Oxford, à Chain, Flory et leurs collaborateurs de compléter en 1940, la découverte de Fleming et de la réaliser de telle sorte qu'elle devienne un médicament d'usage quotidien.

La Pénicilline aujourd'hui tant utilisée se définie: un agent chimique possédant une puissance anti-microbienne exceptionnelle très efficace dans le traitement d'une grande variété d'infections microbiennes. Cette substance est produite par un champignon le *Pénicillium notatum* quand celui-ci est cultivé dans un milieu approprié et dans des conditions favorables.

La Pénicilline distribuée pour usage chimique l'est sous forme de sel de soude. Ce sel se présente sous forme de poudre fine de couleur jaune orange, très soluble dans l'eau et susceptible de se détériorer si elle est soumise à des températures élevées ou même à une température normale

*L'Union Médicale, Sept. 1945.

pendant une période prolongée. La Pénicilline qui a absorbé un certain degré d'humidité perd de sa puissance.

La Pénicilline se présente encore sous forme de comprimés de deux sortes: les uns de couleur grise se nomment "Cillenta" et contiennent chacun 10,000 unités de Pénicilline. Ils sont surtout prescrits dans les cas d'infection de la gorge, le malade les laisse fondre dans la bouche et la Pénicilline agit localement; les autres de couleur jaune pâle s'appellent "Pénoral" et sont dosés à 25,000 unités. Le malade les ingère toutes les deux ou trois heures selon l'ordonnance du médecin. Cette méthode orale est plus agréable au patient mais ses résultats sont plus lents.

"La loi est prononcée il faut avancer", disait Bossuet. La science médicale réalise cette parole à la lettre, elle avance et découvre toujours quelque chose de mieux, ainsi dernièrement elle présentait une nouvelle forme de Pénicillinothérapie, "La Pénicilline en solution huileuse." Pour obtenir cette solution, le sel de soude est d'abord dissous dans un centimètre cube d'eau bi-distillée, ensuite on y ajoute un cc. d'huile d'arrachide composée, ce qui fait une injection de 2 cc. contenant 100,000 unités de Pénicilline. Une dose seulement est administrée chaque jour épargnant ainsi au malade la désagréable sensation de plusieurs piqûres et économisant le temps de l'infirmière. Quant aux résultats, ils sont identiques à ceux que l'on obtient par l'administration du médicament en solution aqueuse toutes les trois heures.

La Pénicilline est habituellement administrée par voie I.V. ou I.M. bien qu'on puisse l'administrer encore par voie buccale, intra-rachidienne, oculaire, sous-cutanée et sur la peau.

A la suite de l'administration par voie parentérale, c'est-à-dire par voie autre que par le tube digestif d'une dose adéquate, le médicament se trouve dans le sang en concentration suffisante pour inhiber la pullutation microbienne. Toutefois à cause de la rapidité de son élimination une concentration inhibitrice ne se trouve dans le sang que pendant une période qui va de trente minutes à deux ou trois heures après une injection I.V., d'une dose thérapeutique moyenne. Après l'administration I.V. d'une dose unique à peu près la moitié de celle-ci est excreté dans les urines. Le comportement de l'autre moitié est encore inconnu.

En dépit d'administration fréquentes et même continues de grandes quantités de Pénicilline par voie I.V. aucune réaction toxique importante n'a été observée. Dans quelques rares cas, des poussées d'urticaire ou de légers malaises accompagnés ou non de température ont été observés, mais étaient-ce bien des réactions de Pénicilline ou simplement coincidence des malaises causés par la maladie et éprouvés à ce moment?

Pour obtenir les meilleurs résultats possibles il est nécessaire d'administrer la Pénicilline d'une façon continue ou à intervalles fréquents pendant une période qui peut aller de sept à quatorze jours ou plus; ceci est nécessaire parce que la Pénicilline est éliminée rapidement par les urines et une large part de la quantité injectée est perdue en quelques heures. Donc, pour que les micro-organismes présents dans les régions infectées soient exposés à la Pénicilline il est essentiel qu'une assez grande quantité du médicament soit administré pour atteindre ce but.

A ce sujet l'histoire de l'un de nos patients servirait bien de preuve. Le 16 janvier 1945, Monsieur X arrivait à l'Hôpital en ambulance. Il venait d'être victime d'une explosion dans une usine de guerre près de Montréal. Agé de trente-six ans, ce patient jouissant d'une bonne santé une seconde avant l'accident, était maintenant dans un état de choc sérieux et fort pitoyable. Pâle, souffrant, extrémités refroidies, P.A. impossible à évaluer, pouls imperceptible et hémorragie à maints endroits de l'abdomen.

Le chirurgien, appelé en toute hâte, procéda à l'examen du blessé. Il déclara qu'une intervention chirurgicale immédiate était tout indiquée pour mettre fin aux hémorragies et empêcher la péritonite de s'installer,

mais que la condition précaire du malade ne permettait pas d'en prendre le risque. Alors il décida d'instituer un traitement médical propre à remonter l'état général de ce patient afin de procéder à l'intervention le plus tôt possible. Aussitôt, transfusion et solutés furent installé presqu'en permanence, on fit des piqûres d'Eschatin et de Coramine pour relever la P.A. et stimuler le coeur. On entoura le malade de sacs chauds, mais que faire pour empêcher la péritonite inévitable due aux perforations certaines de quelques viscères? Il y avait tant de portes d'entrées à l'infection, l'abdomen du patient étant tout criblé de petits trous et la peau noircie par la poudre.

Le médicament fut vite trouvé. Il fallait de la Pénicilline. Vingt mille unités furent régulièrement injectés I.M. toutes les trois heures, de plus des doses semblables furent ajoutées à chaque soluté administré et le malade répondit si bien au soin que l'on pris de lui, qu'au bout de vingt-quatre heures après son arrivée, il était jugé assez fort pour que l'on tenta l'opération.

A la salle d'opération, le chirurgien pratiqua une laparatomie exploratrice et il se trouva en présence de seize perforations dont quinze intestinales et une gastrique, en plus une péritonite des mieux installée. Le chirurgien ne perdit nullement confiance pour tout cela, il fit la résection intestinale nécessaire, sutura l'estomac à l'endroit perforé et referma la paroi en introduisant des mèches pour favoriser le drainage.

Au retour de la salle d'opération, on continua le traitement institué avant l'opération et de plus on injecta dans les veines du plasma alternant avec du sang total et soluté. Outre les autres médicaments pour calmer la douleur, etc., la pénicilline fut continuée par voie I.M. et I.V. Pendant une douzaine de jours, la température du malade variait entre 100° et 102°F., une légère complication pulmonaire vint ajouter à ses souffrances pour quelques jours mais tout rentra vite dans l'ordre. On continuait toujours la Pénicilline toutefois en diminuant les doses à 10,000 unités. Suivant les prescriptions du chirurgien on retira les mèches de drainage et on injecta de la Pénicilline dans chaque plaie pendant trois jours de suite et puis on fit un pansement à la pommade de Pénicilline renouvelable quotidiennement. Au bout de vingt-neuf jours après l'accident, le patient se levait et la 50e journée il quittait l'hôpital guéri et très reconnaissant des soins reçus. Il avait reçu 1,540,000 unités de Pénicilline.

Sans méconnaître le mérite du chirurgien on peut dire que cette guérison est tout à l'honneur de la Pénicilline et il y en aurait bien d'autres dont on pourrait raconter le processus avec avantage et variation, car les doses de Pénicilline sont variables d'un patient à un autre selon le type et la gravité de l'infection.

Actuellement et d'après les expériences faites la Pénicilline est le meilleur agent thérapeutique qui existe pour le traitement de toutes les infections à staphylocoques, à pneumocoques, à streptocoques telles les septicémies, les pneumonies et empyèmes, les méningites, les péritonites, les anthrax, les plaies infectées, les abcès des tissus mous, les ostéomyélites aigues et les endocardites infectes.

Par contre et malheureusement la Pénicilline s'est montrée inefficace dans les cas de typhoïde, de tuberculose, de leucémie, de lupus, de maladie d'Hodgkin, et de cancer.

Qui sera le Fleming de ces maladies? Secret de Dieu! En attendant formons le souhait que bientôt quelque grand génie découvre la médication qui permettra au temple de l'âme immortelle de lutter efficacement contre ces terribles maladies.

Preview

A quarter of a century ago, M. Louisa Parker established her school for the training of attendants to provide nursing care in the home. Her description of the plan she has followed, the success that she has had in controlling the workers, will provide a pattern.

Notes from National Office

General Meeting, C.N.A.

THE MAY ISSUE of the *Journal* carried a tentative outline of the program for the Biennial Meeting of the C.N.A. which is to be held at the Royal York Hotel in Toronto, July 1-4. Since this release, plans have been materially extended under the leadership of Miss Fanny Munroe, the chairman of the Program Committee.

All members who are planning to attend are urged to make railway and hotel reservations well in advance of the date upon which they will arrive. Enquiry should be made regarding convention travel rates at railway centres before purchasing ticket.

At the Executive Meeting of the C.N.A. held in Montreal, it was decided that the meetings of the Executive should be held on June 28, 29, and July 5.

Dr. G. D. W. Cameron, Director of Health Services in the Department of National Health and Welfare, Ottawa, has very kindly consented to take part in the panel discussion Monday, July 1, his topic being "Public Responsibility for Community Nursing Service."

Executive Committee Meeting, C.N.A.

A meeting of the Executive Committee, Canadian Nurses Association, was held in Montreal on March 28-30, 1946, with the president, Miss F. Munroe, in the chair. With one exception, all provinces were represented.

Miss Effie Taylor, president, International Council of Nurses, was present at the executive meeting on Saturday, March 30. It was indeed a pleasure having Miss Taylor with us and to hear about the I.C.N. conference held in London in September, 1945. She also spoke on the Florence Nightingale International Foundation.

The General Secretary reported on the business transacted following the executive meeting held November 30-December 1, 1945. She also reported the preparation of an article, entitled "Nursing in Canada", which interpreted the nursing situation, opportunities, salary schedules, etc. Copies of this article were sent to the editors of the *British Journal of Nursing*, *Nursing Times* and *Mirror* for publication.

It was reported that several enquiries and requests have recently been received from nurses in Great Britain and Europe who wish to visit Canadian hospitals and health organizations for the purpose of studying Canadian methods and procedures in nursing services. An endeavor is being made to prepare a program suited to the needs of the nurses concerned.

RESOLUTIONS AND RECOMMENDATIONS

1. That the C.N.A. submit to the provincial Registered Nurses' Associations, for their consideration and approval, the proposal that the C.N.A. establish a national standard in the teaching of First Aid in schools of nursing by incorporating such a course into the "Proposed Curriculum for Schools of Nursing in Canada", and that a certificate be issued by the C.N.A. to those who have successfully passed an examination in this subject.

2. That if the proposal, that the C.N.A. establish a national standard in the teaching of First Aid in schools of nursing, is accepted

by the provincial Registered Nurses' Associations, the C.N.A. so inform the Federal Minister of Health and such interested groups as the Canadian Medical Association, the Canadian Red Cross Society, and the St. John Ambulance Association, and further that the approach to provincial Ministers of Health and to all provincial groups of the abovementioned organizations be made through the provincial Registered Nurses' Associations.

3. That, inasmuch as funds are limited and other projects seem to be more urgent, further action in regard to the Accrediting of Schools of Nursing be not taken at the present time.

Summary of Provincial Reports

The following is a brief summary of some of the important activities of the provincial associations as contained in the interim reports submitted to this meeting of the Executive Committee, C.N.A.:

Alberta Association of Registered Nurses: The Associated Hospitals of Alberta went on record at their annual convention in Calgary, November 14-16, 1945, as endorsing the sections of the employment schedules presented to them by the A.A.R.N. (For complete details of employment policies see March, 1946, issue of *The Canadian Nurse.*)

Dominion-Provincial grants of $100 each were given to ten students requiring assistance in schools of nursing. Six students were given I.O.D.E. scholarships valued at $100 each.

The director of Nurse Placement Service has visited forty of the ninety-six hospitals in Alberta.

The Alberta minimum curriculum for schools of nursing is at present under revision.

Registered Nurses' Association of British Columbia: A committee on psychiatric nursing has been formed for the purpose of studying the present facilities and the course for affiliating students given at the provincial mental hospital. The findings will enable the committee to make specific recommendations for a broadening of the course and for an expansion of facilities in order that this experience may be made available to all students.

A survey and study of personnel practices is nearing completion and the preparation of a statement of policies is underway.

A special committee has been appointed to bring in recommendations for the revision of the private duty fee schedule.

An experiment in the placement of practical nurses by the Vancouver Regional Branch of Placement Service will, it is expected, get underway soon. In order to protect the public and the service, and to determine the capabilities of the practical nurses who enrol for each placement, a notification of assignment will be mailed to the doctor in attendance and to the patient or a member of his family, and a request for a confidential report when the case has been terminated will be made to the doctor, or to the registered nurse (if a registered nurse has been in contact with the case), or possibly to the patient or a member of his family.

Manitoba Association of Registered Nurses: A meeting of superintendents of nurses and instructors was held to review policies regarding the first-year qualifying examinations for student nurses which have been conducted in Manitoba during the past three years. Twelve of the thirteen schools of nursing in the province were represented at this meeting, and the following recommendations were endorsed (a) that the examination papers be marked in committee; (b) that an Instructors' Institute be held each year under the sponsorship of the M.A.R.N.; (c) that the existing policies regarding the conduct of supplemental examinations and the elimination of students be maintained.

The members approved of the suggestion that the money in the Memorial Fund be invested in Dominion of Canada Bonds and that the interest be used for an annual scholarship to assist a member of the M.A.R.N. to undertake post-graduate study at the School of Nursing Education, University of Manitoba.

New Brunswick Association of Registered Nurses: Studies being undertaken in this province are (a) minimum curriculum; (b) qualifying examinations.

The North Shore Chapter is being organized for the first time.

It was recommended that a letter be sent to the Superintendent of Education, informing him of the apparent lack of knowledge in spelling, composition, grammar, and arithmetic, of high school students admitted to schools of nursing.

The work of the Placement Service is to be carried on in the provincial office with the addition of clerical help.

Registered Nurses' Association of Nova Scotia: Contact was made with the Premier of Nova Scotia requesting representation on the provincial Health Insurance Committee.

The revised application forms for registration are now being considered by the superintendents of nurses in the various schools of nursing in the province.

The convener of the committee to study the establishment of post-graduate courses at Dalhousie University gave a detailed report.

Registered Nurses Association of Ontario: A brief on Nursing Education was submitted to the Royal Commission on Education in Ontario in January, 1946. No report has been received, but it is hoped that consideration may be given and that recommendations will be made by the Commission.

There are twenty-two organized Community Nursing Registries in Ontario. A conference for registrars was arranged for March 27-29. Dr. Frances Triggs was present and assisted with discussion.

A Placement Service was established and is conducted at provincial headquarters.

The second issue of the *News Bulletin* was mailed to every member in November, and a third was ready for distribution the end of February.

Registered Nurses Association of Prince Edward Island: The members were assured that in the event of a health insurance plan being adopted in the province, the association would be given the consideration that was suggested in the Brief that was presented by the members to the Executive Council of the Provincial Government.

A two-day Institute was held by the General Secretary, C.N.A., in February, and a plan outlined for the re-organization of the R.N.A.P.E.I.

Registered Nurses Association of the Province of Quebec: A Bill—"The Quebec Nurses Act"—prepared by the Committee on Legislation and the legal adviser and approved by the Committee of Management, has reached the House. It is designed: (a) to describe nursing legally as a profession and constitute the nurses of the province as a professional body with rights and privileges of such; (b) to require that all professional nurses desiring to practise in the province be licensed. If this Bill is passed, it will reserve the title "nurse" for the exclusive use of members of the R.N.A.P.Q.

French publications available now, or to be available soon, are as follows: (1) Eliason, Ferguson & Farrand's Surgical Nursing Text (6th Ed.); (2) a book, comparable to Harmer's Principles and Practice of Nursing, written by members of the staff at Institut Marguerite d'Youville (Grey Nuns); (3) an edition of the N.O.P.H.N. Manual; (4) Mary Gardner's Public Health Nursing.

Hospital staff shortages are still very acute in some situations, though relieved in others. Enrolment in nursing schools has in general decreased, with several smaller schools suffering considerably. Enrolment in the university courses for graduate nurses is the highest in the history of the province. A five-year combined university and hospital course leading to a degree has been established at Institut Marguerite d'Youville. Students taking this course will receive their clinical experience at Hôpital Notre-Dame.

A brief record of the first twenty-five years' history of the R.N.A.P.Q. will be available in May.

Saskatchewan Registered Nurses' Association: Developments relating to health planning and legislation seem to be maturing quite rapidly in this province. The S.R.N.A., upon request, has prepared recommendations affecting nurses and nursing under a health insurance plan.

Student enrolment is being satisfactorily maintained; the spring classes in all schools in the province were filled.

A copy of the *News Bulletin* prepared by this association was sent with the statement of fees to each member.

A special study is being made of the minimum curriculum for approved schools of nursing in this province, in particular relation to the demands being made upon the graduate nurse.

Two more groups of nurses are organizing in the province, which will bring the total number of chapters up to ten.

British Nurses' Relief Fund

Immediately following the October executive meeting, a further request was received through I.C.N. office to send individual food parcels to nurses in Holland, and lists of names were sent out through National Office to hospital staffs, Students' Councils, and alumnae groups, who responded gladly to this appeal.

The *Journal* has already informed the members of the final number of

OPPORTUNITIES IN NURSING IN CANADA

INSTITUTIONAL NURSING			PUBLIC HEALTH NURSING			NURSING EDUCATION*	PRIVATE PRACTICE AND OTHER
Federal Hospitals	Provincial and Municipal Hospitals	General and Special Hospitals*	Federal Dept. of Indian Affairs	Provincial, Municipal and Civic Depts. of Health	Private Agencies		
POSITIONS OPEN TO NEWLY-GRADUATED NURSES							
D.V.A.—$1,380* **—$1,740 Dept. of Indian Affairs $960*—$1,080	$850—$1,140 + C.L.B.+ Maintenance or $960—$1,380 + part Maintenance	$850—$1,140 + C.L.B.+ Maintenance or $960—$1,380 + part Maintenance	$1,260 + C.L.B.+ Maintenance	$1,050—$1,250 + Allowances	$1,150—$1,380	$1,500	$1,000—$2,200
HOSPITAL NURSE GRADES I, II, III CHARGE NURSE	STAFF NURSE ASST. HEAD NURSE	STAFF NURSE ASST. HEAD NURSE	Due to shortage of nurses with special preparation in these fields, newly-graduated nurses are sometimes appointed by special arrangement				PRIVATE DUTY* (Home and Institution) GROUP NURSING OFFICE NURSE MISSIONARY NURSE (Home or Foreign)
POSITIONS ATTAINED ON THE BASIS OF SUCCESSFUL EXPERIENCE IN NURSING and/or SUPPLEMENTED BY ADVANCED OR SPECIAL PREPARATION							
D.V.A. $2,100* **—$3,600	$1,380—$3,600 + Maintenance	$1,380—$3,600 + Maintenance	$1,260—$2,160	$1,080—$3,600	$1,360—$6,000	$1,500—$4,500	$1,500—$3,000
MATRONS GRADE I GRADE II GRADE III DISTRICT MATRON REGIONAL NURSING CONSULTANT	HEAD NURSE* SUPERVISOR* of Clinical Services i.e. communicable diseases gynaecological medical obstetric orthopedic operating room out-patient	HEAD NURSE** SUPERVISOR** of Clinical Services i.e. communicable diseases gynaecological medical obstetric orthopedic operating room out-patient	STAFF NURSE	STAFF NURSE ASSISTANT SUPERVISOR OR CONSULTANT* SUPERVISOR OR CONSULTANT* ASSISTANT DIRECTOR	STAFF NURSE rendering: general service special service, i.e. industrial maternity and child health orthopedic school college and infirmary	ASSISTANT INSTRUCTOR** *** INSTRUCTOR in: nursing arts science clinical specialties communicable diseases eye, ear, nose and throat	ASSISTANT EXECUTIVE SECRETARY EXECUTIVE SECRETARY REGISTRAR SCHOOL OF NURSING ADVISOR

CONSULTANT	operating room out-patient	operating room out-patient	DIRECTOR	college and infirmary	eye, ear, nose and throat	SCHOOL OF NURSING ADVISOR
ASSISTANT DIRECTOR DIRECTOR OF NURSING	paediatric psychiatric surgical tuberculosis urological etc.	paediatric surgical tuberculosis urological etc.	DIRECTOR OR SUPERINTENDENT	tuberculosis venereal disease, etc. ASSISTANT SUPERVISOR* SUPERVISOR* of: general service special services FIELD SUPERVISOR OR CONSULTANT* ASST. DIRECTOR OR SUPERINTENDENT* EDUCATIONAL DIRECTOR DIRECTOR OR SUPERINTENDENT	gynaecological health education medical obstetric orthopedic out-patient paediatric surgical tuberculosis urological EDUCATIONAL DIRECTOR ASST. DIRECTOR DIRECTOR	DIRECTOR OF PLACEMENT BUREAU EDITOR

*Subject to increase according to promotion plan.

**If living out: less 5% superannuation, plus C.L.B., plus War Duty Supplement.

If living in: less 5% superannuation, less maintenance, plus C.L.B., plus War Duty Supplement if eligible.

*Positions may carry both teaching and administrative responsibilities.

*Including dispensaries, infirmaries, and convalescent homes.

**Positions may carry both teaching and administrative responsibilities.

*Position may carry both teaching and administrative responsibilities.

*Position may carry both teaching and administrative responsibilities.

*Including Schools of Nursing, Nursing Education Departments of Universities.

**Positions may carry responsibilities in the institutional or in the public health nursing field.

***Positions may carry both teaching and administrative responsibilities.

*Salary depends on number of hours or days of employment and type of patient.

For More Detailed Information, Write the

CANADIAN NURSES ASSOCIATION, CRESCENT BLDG., MONTREAL 25

coats and capes sent by the C.N.A. to the Netherlands Red Cross for the exclusive use of the Netherlands Nurses' Association, and many letters expressing deep appreciation of the Canadian gift of clothing have been received by the president, C.N.A. A pathetic request was also received from Miss Rydel, director, University School of Nurses, Cracow, Poland, for clothing of all kinds, including every type of uniform, plus shoes and stockings. This request the C.N.A. unfortunately was unable to meet, but it was referred to the secretary of the I.C.N. and we feel sure the grim need of the Polish nurses will be met.

Correspondence received from Miss Hentsch, Chief of Nursing Division, League of Red Cross Societies, by the I.C.N., and referred to the C.N.A., inferred the possibility of the C.N.A. sending funds to the Red Cross for hospitalization of nurses, from various European countries, who were extremely ill and were being hospitalized in Switzerland. After making enquiries it was considered by the president and members of this committee that we should undertake to help out by sending "comforts" such as soap, tooth-brushes and tooth-paste, bed-jackets and clothing that might be used by these nurses.

As the position of this committee will be reviewed at the biennial meeting, the convener suggested that before making any recommendations as to the final disposition of the fund, a letter be sent to Miss Goodall, Royal College of Nursing, enquiring if there is any need of British nurses that has not or is not being met. A letter was received from Miss Goodall enclosing a financial statement of all funds received from the various Dominions. Details were given concerning several nurses who had been permanently injured, showing what type of assistance had been given. It was interesting to note that in some cases the injured nurse, although unable to carry on nursing duties, received a vocational training and is now able to support herself. It is anticipated that there will be many more new applicants, and Miss Goodall suggested one or two ways in which assistance might be given.

The question arises: Should this fund be continued till every opportunity of giving assistance to British or European nurses in distress has been explored and should the C.N.A. request the government to grant permission to change its officers?

It was decided that the British Nurses' Relief Fund be continued, and that additional funds be raised in order to assist with urgent needs as these present themselves, also that permission be granted to Miss Goodall to use the monies of the B.N.R.F. on hand in England for the provision of houses for British nurses for short rest periods and recuperation following illness. If this fund is not sufficient, that a further amount be forwarded, such amount to be determined by the president and her Advisory Committee in consultation with Miss Goodall, or by the B.N.R.F. Committee.

It was also recommended that the B.N.R.F. be *not* used to provide provincial Registered Nurses' Associations with funds for the purpose of sending food parcels to British nurses or to assist the Netherlands Nurses' Association, as the needs are being met voluntarily by the nurses of Canada.

Publicity and Recruitment

Financial support from Government Grant, for student nurse recruitment and publicity activities, came to an end on March 31, 1946. Service pamphlets, on General Staff Nursing, Tuberculosis and Psychiatric Nursing, are now being prepared to stimulate interest in these nursing fields.

The increase in student enrolment is 44.5 per cent over 1939. The approximate number to graduate in 1945 is 3,523. The expressed opinion of many superintendents of nurses is that the shortage of recruits for nursing during the war years made *desirable selection* of students impossible. Recruitment consists of: (1) publicity to arouse interest; (2) guidance and counselling to direct this interest. We should endeavor to

recruit for "quality" and direct the right student to the right school. Approach should be made *early* in the high school, so that pre-nursing subjects may be taken, eliminating the necessity for special pre-nursing classes in the final year. The recruiting officers for the Women's Services reported that the Services which contacted the freshmen rather than the seniors eventually obtained the most in quantity and best in quality of the college students as recruits.

There should be a continuous supply of information on "Nursing as a Career" available to high school counsellors as they are in a strategic position to aid recruitment of students.

To establish an effective counselling program some plan for follow-up with those students from first and second year, who have indicated an interest in nursing as a career, will be necessary. This might be accomplished through contact of a nurse counsellor with these students or contact of nurse counsellors with the school counsellors.

Copies of the accompanying chart may be obtained free of charge from National Office. It is requested that these charts be placed on notice boards in schools throughout Canada.

Notes du Secrétariat de L'A.I.C.

L'Assemblée Biennale, 1946

L'Assemblée biennale de l'Association des Infirmières Canadiennes aura lieu à Toronto du 1er au 4 juillet. Les séances se tiendront à l'Hôtel-York.

Le programme comporte: deux discussions faites par un groupe; la présentation de rapports importants, entre autres, celui du Comité de Législation, proposant la revision de la loi et des règlements de l'Association.

Une conférence par M. B. K. Sandwell pour honorer la mémoire de Mary Agnes Snively ayant pour titre: "Evolution récente des sentiments humanitaires."

L'espace dans les hôtels est très limité. Pour réservation s'adresser, à Mlle Mathilda Fitzgerald, chambre 715, 86 Bloor Str. ouest, Toronto 5, Ont.

Assemblée du Comité Exécutif

L'Assemblée fut tenue à Montréal, du vingt-huit au trente mars sous la présidence de Mlle F. Munroe. Huit provinces étaient représentées.

Mlle Effie Taylor, présidente du Conseil International des Infirmières, assista à la séance du samedi après-midi, et parla de la conférence tenue à Londres en septembre, 1945. Elle parla aussi de la fondation internationale Florence Nightingale.

De nombreuses demandes de renseignements parviennent d'infirmières d'Angleterre et des autres pays d'Europe, elles sont désireuses de visiter nos hôpitaux canadiens et nos organisations de santé.

Un article a été écrit par Mlle Hall, secrétaire générale, sur la situation du nursing au Canada. L'article a été publié par plusieurs revues anglaises.

L'on s'efforce de préparer un programme convenable pour ces visiteuses éventuelles.

Résolutions: Les résolutions suivantes ont été présentées:

1. Que l'A.I.C. soumette aux associations provinciales des G.M.E. pour considération et approbation le projet suivant: Que l'A.I.C. établisse un standard national dans l'enseignement des Soins d'urgence, et que ce cours soit incorporé au programme d'étude à l'usage des écoles du Canada, et qu'un certificat soit donné par l'A.I.C. à celles qui auront passé avec succès un examen sur cette matière.

2. Que, si cette proposition de l'A.I.C. d'établir un standard national dans l'enseignement des soins d'urgence, est acceptée par les Associations provinciales des G.M.E. que le ministre fédéral de la santé en soit informé par l'A.I.C. et également les associations intéressées dans la matière, tel que la Croix-Rouge canadienne, et l'Ass. Ambulancière St. Jean, et en plus, que les Associations provinciales des G.M.E. en informent respectivement le ministre provincial de la santé et les sections provinciales des Associations déjà citées.

3. Que, comme les fonds sont limités et que d'autres projets semblent plus urgents, aucune autre démarche ne soit faite, pour le temps présent, concernant l'évaluation des écoles d'infirmières.

Resumé des Rapports Provinciaux

L'Association des G.M.E. de l'Alberta: Révision du Programme d'étude: L'Association des hôpitaux de l'Alberta a adopté pour les infirmières des hôpitaux l'échelle de salaire et conditions de travail proposées par l'Association de G.M.E. (Voir *Canadian Nurse* No. de Mars, 1946.)

L'Association des G.M.E. de la Colombie Britannique: Un comité a été nommé dans le but d'étudier les possibilités d'augmenter les affiliations des écoles d'infirmières avec la "Provincial Mental Hospital," afin que toutes les élèves infirmières de la province puissent acquérir de l'expérience en psychiatrie.

Un comité a été chargé de faire des recommendations concernant le révision du tarif du service privé.

Une expérience sera faite prochainement, il s'agit d'un bureau de placement pour les aides de Vancouver. Toutes les mesures ont été prises pour protéger le public, la profession. Les connaissances et l'expérience des aides seront évaluées.

L'Association des Gardes-Malades du Manitoba: Une assemblée des directrices et des institutrices a eu lieu afin de déterminer le plan à suivre, lors des examens d'enregistrement de la 1ère année.

Les recommandations suivantes furent faites (a) que les notes soient données par un comité; (b) que l'on garde la même ligne de conduite concernant les examens supplémentaires et l'élimination des élèves.

L'intérêt d'un fonds spécial sera employé pour un bourse d'étude qui sera donnée à un membre de l'Ass. des G.M. du Manitoba.

L'Association des G.M.E. du Nouveau Brunswick: Sont à l'étude (a) programme d'étude minimum; (b) examen pour certificat d'aptitudes. Une lettre a été adressée au directeur de l'Instruction Publique, l'informant qu'il est apparent que les élèves des écoles primaires supérieures, admises dans nos écoles d'infirmières, manquent de connaissances en orthographe, composition, grammaire et en arithmétique.

L'Association des G.M.E. de l'Ontario: Un mémoire sur l'éducation de l'infirmière fut envoyé à la Commission Royale d'éducation en janvier, 1946. Aucun rapport n'a été reçu, mais l'on espère que l'on en tiendra compte et que des recommandations seront faites par la Commission.

Il y a vingt-deux registres publics organisés en Ontario. A une conférence pour registraires, le Dr. Frances Triggs, fut l'orateur invité.

L'Association des G.M.E. de l'Ile du Prince Edouard: Une conférence qui dura deux jours sous la direction de la Secrétaire Générale de l'A.I.C. eut lieu dans le but de réorganiser l'Ass. des G.M.E. de l'Ile du Prince Edouard.

L'Association des G.M.E. de Québec: La loi des Infirmières de la Province de Québec, a été présentée à la législature. Elle a pour but (a) de faire reconnaitre légalement la profession d'infirmière, et tous les privilèges et droits reconnus à un corps professionnel; (b) d'exiger que toutes les infirmières qui pratiquent dans la province, détiennent une licence.

Si ce projet de loi est accepté, seuls les membres de l'A. des G.M.E. auront le droit de s'appeler infirmières.

Les livres français suivants sont déjà publiés ou le seront prochainement: (1) la Garde-Malade en Chirurgie, par Eliason, Ferguson, et Farrand; (2) un livre comparable à Harmer's Principles and Practice of Nursing, écrit par un membre du personnel de l'Institut Marguerite d'Youville (Soeurs Grises, Montréal); (3) une édition française du Manuel de N.O.P.H.N.; (4) le Nursing en Hygiène Publique, de Mary Gardner.

La situation au point de vue personnel hospitalier semble améliorée dans certains endroits, mais encore difficile dans d'autres.

Les inscriptions dans les écoles d'infirmières ont diminué: par contre les écoles supérieures d'infirmières débordent d'élèves.

Un cours d'infirmière de cinq ans donnant droit à un baccalauréat a été inauguré par l'Institut Marguerite d'Youville. (Affiliée à l'Université de Montréal.) Les élèves qui suivront ce cours auront leur expérience pratique à l'Hôpital Notre-Dame.

L'Association des G.M.E. de la Saskatchewan: L'Association a préparé des recommandations concernant le nursing et les infirmières soumises à un programme d'Assurance Santé.

Etude et révision du programme d'étude ayant en vue ce que l'on demande aujourd'hui à l'infirmière graduée.

La Publicité

L'octroi du gouvernement fédéral donné

à l'A. I. C. pour aider à la publicité et favoriser le recrutement des élèves infirmières est fini. L'augmentation du nombre des élèves a été de 44.5 en 1939. Environ 3,523 infirmières recevront leur diplôme en 1945. Une compagne de recrutement consiste: (1) en la publicité, pour éveiller l'intérêt; (2) des guides et conseillers pour diriger cet intérêt. Nous devons nous efforcer de recruter la qualité.

Des conférences devraient être faites aux élèves dès les premières années du cours primaire supérieur, afin qu'elles étudient le programme qui permettra leur admission à la profession.

Des publications sur la profession d'infirmière devraient êtres mises à la disposition des institutrices. Ce sont elles qui occupent les postes de commande, dans l'orientation des élèves et peuvent diriger les jeunes filles vers nos écoles d'infirmières.

Comité de Secours aux Infirmières Britanniques

A la demande du C.I.I., des secours, vivres, vêtements, ont été envoyés à des infirmières de Hollande.

L'on demande d'aider des infirmières souffrant de tuberculose et actuellement hospitalisées en Suisse. Ces malades viennent de différents pays d'Europe. Des articles de lingerie, gilets de lits, bas, etc., seront envoyés.

Une correspondance a été échangée entre l'A.I.C. et Mlle Goodall, concernant l'emploi des fonds du Comité de Secours aux infirmières britanniques.

Proposed Constitution of Canadian Nurses' Association

ARTICLE I

Name

The Association shall be known as the "Canadian Nurses' Association."

ARTICLE II

Objects

The objects of the Association shall be:

1. To dignify the profession of nursing by maintaining and improving the ethical and professional standards of nursing education and service.
2. To encourage its members to participate in affairs promoting the public welfare.
3. To promote the best interests of the nurses of Canada and to maintain national unity among them.
4. To encourage an attitude of mutual understanding with the nurses of other countries.

ARTICLE III

Membership

1. The membership in the Association shall be divided into classes as follows:
   (a) Honorary Members;
   (b) Association Members;
   (c) Ordinary Members;
   (d) Any other class or classes of members which the Association may by By-law from time to time establish.

Honorary Members

2. Honorary Membership shall be conferred only upon a person who has rendered distinguished service in or for the Nursing Profession or whom it is desired to honor for outstanding public service.

Association Members

3. The following Associations shall be Association Members:
   (a) The Alberta Association of Registered Nurses;
   (b) Registered Nurses' Association of British Columbia;
   (c) The Manitoba Association of Registered Nurses;
   (d) The New Brunswick Association of Registered Nurses;
   (e) The Registered Nurses' Association of Nova Scotia;
   (f) Registered Nurses Association of Ontario;
   (g) The Registered Nurses' Association of the Province of Quebec up to and including the 31st day of December, 1946, and on and after January 1st, 1947, the Association of Nurses of the Province of Quebec;
   (h) The Registered Nurses' Association of Prince Edward Island;
   (i) The Saskatchewan Registered Nurses' Association.

For convenience the foregoing Associations shall be hereinafter referred to collectively as the "Provincial Associations" and/or separately as a "Provincial Association."

Ordinary Members

4. Any nurse who is a duly qualified member in good standing of any Provincial Association shall be an Ordinary Member of this Association.

ARTICLE IV

Powers

The Association shall have power:

(a) To purchase, take on lease or in exchange, hire and otherwise acquire by gift, grant, legacy, devise or otherwise, and to own and hold any estate, property or rights, real or personal, moveable or immoveable, or any title or interest therein, and to sell, exchange, alienate, manage, develop, mortgage, hypothecate, lease or otherwise deal therewith as it may deem advisable for the purposes of the Association.

(b) To borrow money for the purposes of the Association.

(c) To draw, make, accept, endorse, discount, execute and issue promissory notes, bills of exchange and other negotiable or transferable instruments.

(d) To own, operate, print, publish and distribute journals, periodicals and publications for the professional advancement of the members of the Association, including but without limiting the generality of the foregoing the Journal known as "The Canadian Nurse", and to own, hold, acquire, sell, dispose of and otherwise deal with the shares of any company which may own, operate, print, publish and distribute "The Canadian Nurse" or any other such journal, periodical or publication, and in connection therewith to lend money to, to guarantee the contracts of, or otherwise assist any company, society, firm, committee, persons or person, which may be charged with the duty of

owning, operating, printing, publishing or distributing "The Canadian Nurse" or such journal, periodical or publication.

(e) To establish and support or aid in the establishment and support of associations, institutions, funds, trusts and conveniences calculated to benefit nurses and the nursing profession in any way, and to subscribe or guarantee money for charitable or benevolent objects or for any exhibition or for any public, general or useful object.

(f) To invest and deal with the moneys of the Association not immediately required in such manner as may from time to time be determined.

(g) To do all such lawful acts and things as are incidental or conducive to the attainment of the objects and the exercise of the powers of the Association.

(h) To make, amend and repeal By-laws and regulations for any and all purposes of the Association not inconsistent with the provisions hereof and without limiting the generality of the foregoing for defining and regulating:

(i) the terms and conditions of membership in the Association and the rights, duties and privileges of members including their voting rights;

(ii) the number, powers and duties of the officers of the Association and the constitution, powers, duties, quorum, term of office and method of election of the Executive Committee and all other Committees of the Association;

(iii) the time and place for holding general or special meetings of the Association and the notice and other requirements thereof, except that general meetings of the Association shall be held only in every second year unless the Association otherwise decides;

(iv) the amount of the fees, assessments and dues payable by the members;

(v) the administration and management of the business and affairs of the Association and the furthering of its objects and purposes.

ARTICLE V

Executive Committee

The affairs of the Association shall be managed by an Executive Committee which shall be composed, elected or appointed as the Association may by By-law prescribe from time to time, and which shall have the powers set out in the By-laws of the Association.

ARTICLE VI

Tenure of Present Officers and Committees

The present officers of the Association, the members of the Executive Committee and of the Committees appointed under the provisions of the Constitution and By-laws of the Association existing prior to the enactment of this Constitution shall continue to hold their offices until their successors have been appointed or elected in accordance with the provisions of this Constitution and of the By-laws made hereunder.

All Sections of the Association shall cease to exist upon the enactment of this Constitution.

ARTICLE VII

Amendments

This Constitution may be added to, repealed, amended or re-enacted at any time in the same manner as the By-laws of the Association may be added to, repealed, amended or re-enacted, and the provisions of the said By-laws relating to the amendment thereof shall apply to any amendment to this Constitution.

Proposed By-Laws of Canadian Nurses' Association

BY-LAW I

Membership

Honorary Members

SECTION 1. The name of any candidate for Honorary Membership must be submitted to and approved of by the Executive Committee, after which it may be submitted to any General Meeting of the Association by which Honorary Membership may be conferred by an unanimous vote. There shall not be, at any one time, more than twenty-five Honorary Members, and not more than two persons shall be elected as Honorary Members at any General Meeting. Honorary Members will not be required to pay fees.

Annual Membership Fees

SECTION 2. An annual membership fee of $1.00 per member shall be collected by the Provincial Association to which each nurse belongs and shall be remitted to this Association by the said Provincial Association on March 31st, June 30th, September 30th or December 31st following the date of collection as the case may be.

Forfeiture of Ordinary Membership

SECTION 3. Any nurse who fails to remain in good standing with the Provincial Association to which she belongs or who ceases to be a member of such Provincial Association shall *ipso facto* forfeit her membership in this Association.

BY-LAW II

Executive Committee

Composition

SECTION 1. There shall be an Executive Committee of the Association to be known as the "Executive Committee", which shall be composed as follows:

(a) The Officers of the Association, excluding the Treasurer and the General Secretary.

(b) Two representatives from each Provincial Association who shall be:

(i) The President of such Provincial Association, but, in the event that such President is unable for any reason to attend any meeting of the Executive Committee, she may designate in writing a Vice-President, or any other officer or any other member of the administrative body, or the Executive Secretary of such Association, to attend such meeting for and on her behalf;

(ii) Any other member of the administrative body of such Association or the Executive Secretary of such Association as may be designated for such purpose by such Association.

Each of these said two representatives will be entitled to one vote at all meetings of the Executive Committee, but if only one representative of such Association be present at any meeting, such representative shall be entitled to two votes upon all matters which are voted upon at the said meeting.

If the Executive Secretary of such Provincial Association be not one of the two representatives of such Association at any meeting, such Association shall be entitled to have the said Executive Secretary attend such meeting of the Executive Committee, but such Executive Secretary shall have in such event no voting rights.

(c) The immediate Past President of the Association.

(d) The Chairmen of the following Standing Committees:

(i) The Committee on Institutional Nursing;

(ii) The Committee on Private Duty Nursing;

(iii) The Committee on Public Health Nursing;

(iv) The Committee on Educational Policy;

(v) The Committee on Constitution, By-laws and Legislation;

(vi) The Committee on Labour Relations.

Meetings

SECTION 2.

(a) A minimum of two meetings of the Executive Committee shall be held each year.

(b) A meeting shall also be held immediately before before and immediately following a General or a Special Meeting of the Association.

(c) Meetings shall be held at the Head Office of the Association or at such other place and at such time or times as the Executive Committee may itself designate, or in the absence of designation by the Executive Committee, as may be designated by the President.

Chairman and Secretary of Meeting

SECTION 3. The President of the Association or, in her absence, any Vice-President in order of position, shall preside at all meetings of the Executive Committee. In the absence of the President and any Vice-President, the members of the Executive Committee shall choose from among their number a Chairman. The General Secretary of the Association shall act as Secretary at all meetings but she shall not be entitled to vote thereat. In the absence of the General Secretary, one of the Assistant Secretaries of the Association shall act as Secretary of the Meeting, and in the absence of any such Assistant Secretary, the members of the Executive Committee shall elect any suitable person to act as the Secretary of the Meeting.

Notices of Meetings

SECTION 4. Notices of meetings of the Executive Committtee shall be given by the General Secretary by letter posted to or delivered at the usual place of business or residence of each member and Association Member thereof at least four weeks before such meeting. No notice shall be necessary for the meeting to be held immediately after a General or a Special Meeting of the Association.

Voting Power

SECTION 5. Members of the Executive Committee shall vote in person and each member will have one vote except in the case of a Provincial Representative who shall, in the circumstances set out in subsection (b) of Section 1 of this By-law II, have two votes. In case of a tie, the Chairman at such meeting shall be entitled to a casting vote in addition to her own vote or votes as a member of the Executive Committee.

Quorum

SECTION 6. The quorum for a meeting of the Executive Committee shall be nine. Five provinces shall be represented in the quorum.

Resignation or Death

SECTION 7. If an officer of the Association or a member of the Executive Committee should resign, die or otherwise cease to act as an officer or member, she may be replaced at any time in the manner determined by the By-laws. If there be no provision in the By-laws for such replacement, then the Executive Committee may make such replacement in its entire discretion, except in the case of the replacement of a representative of a Provincial Association in which case the replacement shall be made by the Provincial Association concerned.

Powers

SECTION 8. The Executive Committee, subject to any special provision of the Constitution and By-laws, shall have the following powers:

(a) The conduct, control, transaction, management, administration and supervision of all the property, affairs and business of the Association in all things and of all kinds and descriptions without any limitation except as may be set out in the Constitution and By-laws.

(b) The power to make or cause to be made for and on behalf of the Association any kind or description of contract, agreement, document or writing which the Association may by law enter into, and from time to time to pass By-laws not contrary to law or to the Constitution and By-laws, for the purpose of regulating the affairs of the Association.

(c) The power to authorize any person or persons to make, sign, draw, accept or endorse all promissory notes, cheques and other bills of exchange and all negotiable instruments for and on behalf of the Association and to sign and execute all contracts, agreements, deeds of sale or of purchase, grants, indentures, leases, mortgages, deeds of hypothec and documents in writing to be signed or executed by or on behalf of the Association, all of which, when so signed or executed by the person or persons so authorized, shall be binding upon the Association, and further to authorize such person or persons to affix whenever necessary the corporate seal of the Association to any such document or documents.

(d) The power to appoint and remove all appointed officers, agents and servants of the Association, to determine their functions and their remuneration and to determine what officers, agents and servants shall be bonded and the amount of any such bond.

(e) The obligation to report fully to the Association at each General Meeting upon the business transacted since the last General Meeting.

(f) To decide upon the exact date and place for holding any General Meeting of the Association and any Special Meeting of the Association as the case may be and to call the same.

BY-LAW III

Sub-Committee of the Executive Committee Composition

SECTION 1. For the purpose of facilitating the affairs of the Association, there shall be a Sub-Committee of the Executive Committee to be composed as follows:

(a) The President;
(b) The First Vice-President;
(c) The Second Vice-President;
(d) The Third Vice-President;
(e) The immediate Past President.

Powers

SECTION 2. The Sub-Committee of the Executive Committee shall have the power to administer the affairs of the Association between meetings of the Executive Committee subject to the Constitution and By-laws of the Association and to any restrictions or limitations imposed by the Executive Committee.

BY-LAW IV

Officers of the Association

SECTION 1. The Officers of the Association shall be the following:

(a) The President;
(b) The First Vice-President;
(c) The Second Vice-President;
(d) The Third Vice-President;
(e) The Treasurer;
(f) The General Secretary.

Term of Office

SECTION 2. All elected officers shall hold office until the conclusion of the next General Meeting after their election. No officer shall be elected to the same office for more than two consecutive terms.

President

SECTION 3. The President shall preside at all meetings of the Association, and of the Executive Committee, and shall be *ex officio* a member of all Committees except the Nominating Committee. She shall perform all acts and deeds pertaining to her office and shall exercise a general control and supervision over the affairs of the Association.

Vice-Presidents

SECTION 4. Each Vice-President shall have such powers and shall perform such duties as may be assigned to her by the Executive Committee or by the President. In the case of the absence of the President or of her inability to act as such at any time and for any reason, the Vice-Presidents in order of position shall perform all the duties of the office of President.

Treasurer

SECTION 5. The Treasurer shall be appointed by the Executive Committee. She shall have the general control of the finances, the moneys and the securities of the Association except insofar as the Executive Committee may otherwise decide. She shall keep full and accurate accounts of receipts and disbursements in books belonging to the Association and shall deposit all money and other valuable securities in the name and to the credit of the Association in such bank or banks or depository as the Executive Committee may from time to time designate. She shall make all payments by cheque. She shall render to the Executive Committee and to the President, at least once a month, and whenever otherwise directed by either of them, an account of all her transactions as Treasurer and of the financial position of the Association as may be required. She shall submit to the auditor or auditors of the Association all books of the Association for examination whenever she is required to do so by the Executive Committee or by the auditor or auditors of the Association. She shall prepare a budget of the estimated

expenses of the Association for the succeeding two years, counting from the date of the next General Meeting, for submission to each General Meeting. She shall turn over to her successor in office within one month after her successor shall have been appointed, all the property of the Association in her possession. She shall perform all acts incidental to her office as Treasurer of the Association subject to the control of of the Executive Committee.

General Secretary

SECTION 6. The General Secretary shall be appointed by the Executive Committee to hold office upon such terms and conditions of employment and at such salary as may be determined by the Executive Committee. She shall attend and keep proper records of meetings of the Association and the Executive Committee, and shall have charge of all the books and records except insofar as the Executive Committee may otherwise arrange. She shall send as soon as possible to all members and Association Members thereof the minutes of all business transacted at any meeting of the Executive Committee. She shall notify Officers of their election and Members of the Executive Committee and all Committee Members of their appointment. She shall turn over to her successor in office within one month of the appointment of such successor all the property of the Association in her possession. She shall perform all duties imposed upon her by the Constitution and the By-laws, and generally shall perform all such other duties as appertain to her office or which may be incidental thereto, or as may be required by the Executive Committee or the President.

General Secretary-Treasurer

SECTION 7. The Executive Committee may, at any time, combine the positions of Treasurer and General Secretary, and in such event the person so appointed to both of such offices shall be known as the "General Secretary-Treasurer."

BY-LAW V

Nominating Committee

Composition

SECTION 1. There shall be a Nominating Committee of five members, two of whom shall be appointed by the Executive Committee and three of whom shall be elected by ballot by the Voting Delegates at each General Meeting.

Chairman and Secretary

SECTION 2. The Chairman of the Nominating Committee shall be chosen from among its members by the members of the Committee at its first meeting. The General Secretary of the Association shall act as Secretary of the Committee.

Request for Nomination

SECTION 3. On or before the 1st day of October preceding the next General Meeting of the Association, the Secretary of the Committee shall request each Provincial Association to nominate at least one candidate for each of the offices and elected chairmanships of National Committees in the Association, which candidate must be qualified to hold such office or chairmanship.

Submission of Nominations

SECTION 4. All Provincial Associations shall submit to the Secretary of the Committee on or before the 31st day of December following, all nominations made by them, which nominations must be signed on behalf of such Associations by the President and the Secretary thereof. Every nomination must be accompanied by a consent, signed by the person nominated, agreeing to serve if elected.

Manner of Nominating

SECTION 5. The Secretary of the Committee shall send a copy of all nominations so received to each member of the Nominating Committee as soon as possible after the said 31st day of December. The members of the Committee shall carefully consider all the nominations received and shall select therefrom for each office and chairmanship the names of the two candidates who have received the highest number of nominations for such office or chairmanship, provided however that if there be more than two candidates for any office or chairmanship who have received the highest number of nominations by reason of any equality of nominations among them, then all such candidates so receiving the highest number of nominations shall be so selected. As soon as the list of candidates has been so prepared it shall thereafter be known as the "Ticket of Nominations", and a copy of it, signed by the Chairman and the Secretary of the Committee, shall be sent not later than the 31st day of March following, to each Provincial Association.

Quorum

SECTION 6. A quorum at any meeting of the Nominating Committee shall be three.

Qualification for Nomination

SECTION 7. Any person nominated for any office or chairmanship in the Association must be an Ordinary Member in good standing of the Association.

Nomination

SECTION 8. No person may be nominated for any office or chairmanship in the Association except by the Nominating Committee, and no nomination may be made other than in the manner above set forth. The Chairman of the Nominating Committee shall file a copy of the Ticket of Nominations with the President of the Association before the next General Meeting of the Association, and the filing of such a copy with the President shall constitute the official nomination of the parties therein named to the offices and chairmanships in question.

Provision for Additional Nominations

SECTION 9. In case any of the candidates nominated by the Nominating Committee should die, refuse in writing to stand for such office or chairmanship, be unable to do so, or become disqualified in any way from so doing before any election takes place, any Voting Delegate may nominate for any such office or chairmanship any Ordinary Member of the Association whose name was put in nomination for any office or chairmanship to the said Nominating Committee, and any nomination so made must be filed with the President before the election.

BY-LAW VI

Elections and Voting

Voting Body

SECTION 1. The Voting Body at each General or Special Meeting of the Association shall consist of the Voting Delegates from the Provincial Associations.

Voting Delegates

SECTION 2. Each Provincial Association shall be entitled to appoint three Voting Delegates in respect of its first fifty (50) members or any part thereof; plus one additional Voting Delegate for any members over fifty (50) members up to and including one hundred (100) members; plus one further additional Voting Delegate in respect of any members in excess of one hundred (100) members and up to and including three hundred (300) members; plus one further additional Voting Delegate for every three hundred (300) additional members or any part thereof if the total membership of such Provincial Association exceeds three hundred (300) members.

Membership as used in this section shall mean members who are fully paid-up members of and in good standing with the Provincial Association in question.

Voting Rights of Voting Delegates

SECTION 3. Each Voting Delegate shall have, at least, one vote for each office in the election of officers and on all matters which come before any General or Special Meeting. Any Provincial Association may, however, give and grant to any one or more of its Voting Delegates the right to cast in addition to her own vote, any number of votes up to a number not to exceed for all Voting Delegates of such Provincial Association the total number of votes to which such Association is entitled under the provisions of Section 2 of this By-law VI. Each Provincial Association must certify in writing under the signature of its President

the number of votes which each Voting Delegate may cast, which writing must be delivered to the General Secretary prior to the commencement of the General or Special Meeting in question.

Appointment of Voting Delegates

SECTION 4. The Voting Delegates shall be appointed or elected in such manner as the Provincial Association in question shall determine. Each Provincial Association shall furnish to the General Secretary of the Association before the opening of the meeting in question a certified list of its Voting Delegates, and only such Voting Delegates named in such lists shall in any event have any right to vote at the said meeting.

Qualification of Voting Delegates

SECTION 5. Every Voting Delegate must be an Ordinary Member in good standing of this Association.

Identification of Voting Delegates

SECTION 6. Each Voting Delegate must be furnished with a letter or card of identification signed by the President and the Secretary of the Provincial Association which such Voting Delegate represents, duly identifying such Voting Delegate and which letter or card must be presented to the General Secretary at the time of the registration of such Voting Delegate for the meeting in question.

Scrutineers

SECTION 7. Before any election is had or any vote is taken, the Chairman of the meeting shall appoint any two Ordinary Members who are not Voting Delegates, to act as scrutineers. The General Secretary shall forthwith furnish to each scrutineer a certified list of the Voting Delegates of each Provincial Association entitled to vote at the meeting, together with a certified statement of the voting rights of each Voting Delegate. The scrutineers shall arrange for the holding of any election and shall distribute, collect and count the ballots and report the results in writing to the Chairman of the Meeting.

Election of Officers and Chairmen

SECTION 8. The elective Officers and Chairmen of the Association shall be elected by ballot at the General Meeting. The candidate receiving the highest number of ballots for each office and chairmanship shall be declared elected by the Chairman. For elections the polls shall be open for a period of two hours from the time that the voting commences. Each Voting Delegate shall individually cast her vote or votes.

Voting on Resolutions and Motions

SECTION 9. In all matters other than for the election of officers and chairmen, voting shall be by a show of hands, unless any Voting Delegate shall demand a poll. Any Voting Delegate shall be entitled to demand a poll at any time before a vote is taken upon a motion or resolution, and in the event of any such demand, the voting shall be by ballot. In any voting by a show of hands, the Chairman of the Meeting shall decide the results and shall with the scrutineers, if necessary, make such count of the votes so given by a show of hands as she may consider necessary, and her decision shall be final. If a poll be demanded and the voting be by ballot, the votes shall be taken forthwith by ballot by the scrutineers who shall report the result in writing to the Chairman who shall announce the result to the Meeting immediately thereafter. All resolutions and motions shall be decided by a majority vote unless it is otherwise specified in the Constitution or in any By-law.

Casting Vote in Case of a Tie

SECTION 10. In the case of a tie vote, whether for the election of an officer or chairman or upon any motion or resolution, the Chairman of the meeting shall in all cases have a casting vote in addition to any vote which she may otherwise have as a Voting Delegate.

Additional Rules and Regulations for Voting

SECTION 11. The Executive Committee may make any rules and regulations for the holding of elections and voting and for making all the necessary arrangements therefor as it may consider advisable, which rules and regulations shall not conflict with the foregoing. The General Secretary shall keep a copy of any such rules and regulations for inspection by the members at any time.

BY-LAW VII

Meetings of the Association

SECTION 1. A General Meeting of the Association shall be held in the year 1946 and biennially thereafter at such time and at such place as may be decided upon by the Executive Committee. Any business may be transacted thereat.

Special Meetings of the Association

SECTION 2. A Special Meeting of the Association may be held at any time and at any place as may be determined by the Executive Committee or the three Provincial Associations calling the same as the case may be, and may be called by:

(a) The Executive Committee;
(b) Any three Provincial Associations acting together, but only if the Executive Committee has refused or failed to call a Special Meeting within thirty days after the same three Provincial Associations have requested the Executive Committee by application in writing to do so, which application must set out the reasons for the Special Meeting and the business to be transacted thereat.

Business of Special Meetings

SECTION 3. No business shall be transacted at a Special Meeting except such business as shall be specified in the Notice thereof.

Notices of Meetings

SECTION 4. A Notice of each General Meeting shall be sent to each Association Member by the General Secretary by letter mailed to such member at least sixty days before the date of the General Meeting, and a Notice of each Special Meeting shall be sent to each Association Member by the General Secretary by letter mailed to such member at least thirty days before the date of such Special Meeting, to the address of such member in the records of the Association. Such notice shall indicate the time and place of the meeting. It shall not be necessary to register such letters. The Notice for a Special Meeting must specify the business to be transacted thereat and the General Secretary shall be obliged to send out notices for a Special Meeting so soon as it has been called. Irregularity in the Notice or in the giving thereof as well as the accidental failure to give such notice to or the non-receipt of any such notice by any of the members entitled thereto shall not invalidate anything done or passed at any such meeting. A copy of the notice shall also be published in the first issue of "The Canadian Nurse" after its mailing. It shall not be necessary to send a notice of any meeting to an Ordinary Member.

Quorum

SECTION 5. The quorum at any General Meeting of the Association shall be eighty Ordinary Members. Six Provincial Associations must be represented by Voting Delegates.

The quorum at any Special Meeting of the Association shall be forty Ordinary Members. Five Provincial Associations must be represented by Voting Delegates.

Officers at Meeting

SECTION 6. In case the President or any of the Vice-Presidents be unable to preside at any General or Special Meeting, a Chairman shall be chosen by the Meeting. In case the General Secretary, or in her absence one of the Assistant Secretaries of the Association, should be unable to act as Secretary of the Meeting, the Chairman of the Meeting shall choose a Secretary for the Meeting.

Proposing of Resolutions and Motions

SECTION 7. Only Voting Delegates shall have the right to move or second any resolution or motion at a meeting.

Order of Business

SECTION 8. The order of business at any General or Special Meeting shall be determined by the Execu-

tive Committee prior to the opening of the Meeting in question. The order of business at any General Meeting shall in any event include the following items:

(a) Opening prayer;
(b) Reading of the Minutes of the last General Meeting and of any Special Meeting held since the last General Meeting;
(c) Report of the Executive Committee;
(d) Report of the President;
(e) Reports of National and Special Committees;
(f) Nomination of Officers;
(g) Election of Officers;
(h) New business;
(i) Election of Chairmen of Committees.

BY-LAW VIII

National Committees and Special Committees

SECTION 1. The National Committees of the Association shall be the following:

(a) The Committee on Institutional Nursing;
(b) The Committee on Private Duty Nursing;
(c) The Committee on Public Health Nursing;
(d) The Committee on Educational Policy;
(e) The Committee on Constitution, By-laws an Legislation;
(f) The Committee on Labour Relations;
(g) The Committee on Health Insurance;
(h) The Committee on Programme;
(i) The Committee on Arrangements;
(j) The Committee on Student Nurse Activities

Chairmen of National Committees

SECTION 2. The Chairmen of the Committees on Institutional Nursing, Private Duty Nursing and Public Health Nursing, shall be elected by ballot by the Voting Delegates at each General Meeting. The Chairmen of the other National Committees shall be appointed by the Executive Committee at its first meeting following the General Meeting of the Association. All Chairmen shall hold office from their election or appointment as the case may be until the conclusion of the next General Meeting. No Chairman shall hold office for more than two consecutive terms.

Appointment of National and Special Committees

SECTION 3. The members of all National Committees shall be appointed by the Executive Committee at its first meeting after each General Meeting to serve until the conclusion of the next General Meeting. Only Ordinary Members in good standing of the Association may be appointed to Committees. Special Committees may be appointed by the President or the Executive Committee at any time.

Composition of National Committees

SECTION 4. All National Committees shall consist of: a Chairman; a Vice-Chairman; a Secretary; a Member of the Secretarial Staff of the Association; three Ordinary Members of the Association located in the vicinity of the residence of the Chairman, to facilitate the work of the Committee. The Executive Committee shall, at its entire discretion, have the right at any time and from time to time as it may deem advisable to increase the number of the members of any Committee.

Committee on Institutional Nursing

SECTION 5. The Committee on Institutional Nursing shall:

(a) Implement policies of nursing education and practice as recommended by the Committee on Educational Policy and approved by the Executive Committee.
(b) Be concerned with:
  (i) special problems of administration, supervision and teaching in Hospitals and Schools of Nursing;
  (ii) Nursing Service, both graduate and undergraduate.
(c) Promote public interest in Hospitals and Schools of Nursing.
(d) Promote a higher standard of service through post-graduate study.

Committee on Private Duty Nursing

SECTION 6. The Committee on Private Duty Nursing shall endeavour:

(a) To establish and maintain a constructive and sympathetic relationship among all Nurses engaged in Private Duty Nursing in Canada.
(b) To establish a mutual understanding between Nurses engaged in Private Duty Nursing and Nurses in other branches of the profession.
(c) To promote a higher standard of service through post-graduate study.

Committee on Public Health Nursing

SECTION 7. The Committee on Public Health Nursing shall endeavour:

(a) To establish and maintain a constructive and sympathetic relationship among all Public Health Nurses;
(b) To keep the Association informed upon the progress of Public Health Nursing;
(c) To advance the cause of Public Health in general by fostering a high standard of service;
(d) To promote a higher standard of service through post-graduate study.

Committee on Educational Policy

SECTION 8. The Committee on Educational Policy shall:

(a) Formulate policies for recommendation to the Executive Committee in regard to Nursing Education, both graduate and undergraduate, which will assist the Nursing Profession to meet the changing demands in respect to Nursing Service.
(b) Assume direction for studies or demonstrations required to implement any change in policy recommended by the Executive Committee.

Committee on Constitution, By-laws and Legislation

SECTION 9. The Committee on Constitution, By-laws and Legislation shall consider carefully the Constitution and By-laws of the Association and suggest to the Executive Committee such amendments thereto as may be advisable from time to time. It shall also inform itself with regard to all Dominion, Provincial and Municipal Legislation, Orders-in-Council, Rules and Regulations affecting Nurses and the Nursing Profession and it shall make to the Executive Committee such reports and such recommendations thereon as it may deem advisable from time to time.

Committee on Labour Relations

SECTION 10. The Committee on Labour Relations shall study carefully all matters relating to Labour Relations affecting Nurses in their capacity of employers or employees and shall inform itself with regard to all matters relating to Collective Bargaining, Labour Laws and Regulations, and generally with regard to the position of Nurses as employers or employees to protect the position and the employment of Nurses as much as possible.

Committee on Health Insurance

SECTION 11. The Committee on Health Insurance shall study carefully and keep in touch with Health Insurance Schemes, and have information available as may be required by the Association in the event of the adoption of a general plan of Health Insurance, Federal or Provincial.

Committee on Programme

SECTION 12. The Committee on Programme for Meetings of the Association shall prepare and arrange the programme of papers and discussions at any General or Special Meeting of the Association, and subject to the approval of the Executive Committee it shall prepare a complete programme and order of business for each General or Special Meeting.

Committee on Arrangements

SECTION 13. The Committee on Arrangements for Meetings of the Association shall make all the local arrangements for every General and Special Meeting and shall superintend the registration of members and visitors and shall arrange for their entertainment. This Committee may appoint a sub-committee of members who are residents of the city in which any General or Special Meeting is to be held during its term of office. The Chairman shall be a resident of the city in which the next General Meeting of the Association is to be held.

Committee on Student Nurse Activities

SECTION 14. The Committee on Student Nurse Activities shall:

(a) Encourage the organization of Student Nurse Associations in Canada and promote professional interest among Student Nurses;

(b) Endeavour to interpret to students the aims and objects of Professional Nursing Organizations;

(c) Arrange a program of interest to students at General Meetings of the Association.

Special Committee to be known as "The Editorial Board for 'The Canadian Nurse' "

SECTION 15. The Editorial Board for "The Canadian Nurse" shall consist of three members located in or near the city where the office of "The Canadian Nurse" is situated, and shall be appointed by the Executive Committee of the Association. The Editorial Board shall act in an advisory capacity to the Editor and Business Manager of "The Canadian Nurse" in matters relating to Editorial Policy, Finance and Business Management. The Editor shall attend all meetings of the Editorial Board and shall act as Secretary of the Board.

Death or Resignation of Committee Member

SECTION 16. If any member of a Committee should die, resign or otherwise cease to act during her term of office, the Committee in question shall be entitled at any time to replace such member from among the Ordinary Members of the Association. If the Chairman of any Committee should die, resign or otherwise cease to act, a new Chairman shall be appointed by the Executive Committee of the Association.

Quorum

SECTION 17. The quorum at any meeting of a National Committee shall be four. The quorum at any meeting for a Special Committee shall be a majority of the members thereof, but in determining a quorum for a Special Committee the President shall not be counted as part of the Committee unless she is present at the meeting in question.

BY-LAW IX

Seal

The Association shall have a Seal, which shall consist of the words "Canadian Nurses' Association Founded 1908" enclosed in a circle. Any Officer of the Association and such other person or persons as may be so authorized by a resolution of the Executive Committee shall each have authority to affix the seal of the Association to any official document.

BY-LAW X

Fiscal Year

The fiscal year of the Association shall be the calendar year.

BY-LAW XI

Auditors

An Auditor or Auditors shall be appointed by the Executive Committee at its first meeting held after the General Meeting of the Association to hold office until after the conclusion of the next General Meeting. Whenever any vacancy occurs in the position of Auditor or Auditors before the end of the term, that vacancy may be filled by the Executive Committee for the balance of the term. While any such vacancy continues the remaining Auditor or Auditors, if any, may continue to act.

The Auditor or Auditors so appointed shall make an annual audit of the books of the Association as soon as possible after the close of the fiscal year and shall report thereon to the Executive Committee.

BY-LAW XII

Amendments

SECTION 1. These By-laws or any Section thereof may be added to, repealed, amended or re-enacted at any time by a majority vote of those Voting Delegates present and voting at any General or Special Meeting of the Association. Notice of any proposed amendment must be given to the General Secretary at least three months prior to the date of any General or Special Meeting at which the amendment is to be voted upon and a copy of the said notice must, within one month after the receipt thereof by the General Secretary, be mailed by her to each Association Member. The notice must contain full particulars of the proposed amendment and be signed by two Association Members as proposer and seconder respectively.

SECTION 2. These By-laws may be amended at any General Meeting by an unanimous vote of all the Voting Delegates present and voting, without any previous notice of any kind; provided, however, that no such amendment shall affect or change the accepted policy of the Association.

Department of Veterans Affairs

EASTERN REGIONAL NURSING CONSULTANT

Mima M. Maclaren, R.R.C., joined the nursing service of this Department on April 1, 1946, as the new Eastern Regional Nursing Consultant. The Eastern region extends from the Maritimes to the Manitoba-Ontario border. She will work in conjunction with Mr. P. B. Cross, the recently-appointed Eastern Regional Administrator, and Dr. E. B. Convery, the Eastern Regional Medical Officer. Their headquarters will be Ottawa.

The Department and the Matron-in-Chief are happy to welcome Miss Maclaren to this new position, for which her wide experience with the R.C.A.M.C. overseas fits her so well. Prior to returning to Canada, Miss Maclaren was the senior principal matron with the Canadian Army in Western Europe.

A conference is being held in Ottawa at the Chateau Laurier on June 28-29, 1946, for D.V.A. hospital matrons, just prior to the Biennial meetings of the Canadian Nurses Association and Nursing Sisters' Association on July 1-4, in Toronto. This is the first conference of its kind to be conducted by the Department of Veterans Affairs.

For purposes of administration within the Department of Veterans Affairs, Canada is divided into administrative districts, each with a District Administrator and district office establishment. The Treatment Branch is represented in this district organization by the Medical Adviser to the District Administrator. One matron is designated to act as district matron and to represent the Matron-in-Chief in district nursing affairs at district office or with the district Civil Service Commission representative.

Very recently organization plans were developed to provide for Eastern and Western Regional headquarter staffs as well. The dividing line is the Manitoba-Ontario border, and in each region there is a Regional Administrator, a Regional Medical Officer, and a Regional Nursing Consultant.

TREATMENT SERVICES
HOSPITALS AND INSTITUTIONS

District	*District Headquarters*	*Hospitals & Institutions*	*Location*	*No. of Beds*	*Type of Service*	*Matron or Nurse-in-Charge*
A	Montreal	Ste. Annes	Ste. Anne de Bellevue	1022	G. & P.	N.B.Kennedy-Reid
		St. Hyacinthe Vet. Hosp.	St. Hyacinthe	100	T.	C. A. J. Evans
		Lachine Vet. Hosp.	Lachine	200	T.	M. L. G. MacLellan
		Queen Mary Road (M)	Montreal	500		
		Huntingdon (*Inst.*)	Huntingdon	300	H. & O.	F. L. Walker
B	Halifax	Camp Hill	Halifax	558	G.	S. C. MacIsaac (District)
		Veterans Home (*Inst.*)	Halifax	25	V.C.	E. C. Duthie
		Cornwallis	Cornwallis	250	T.	M. B. MacNeill
		Cornwallis (*Inst.*)	Cornwallis	300	H. & O.	
		Sydney	Sydney	200	G.	
C	Ottawa	(Ottawa Civic Vet. Pav.)				
		Rideau (M)	Ottawa	225		
		Rideau (*Inst.*)	Ottawa	225	H. & O.	
D	Toronto	Christie St.	Toronto	1488	G. & S.T.	D. L. Kent
		Lyndhurst Lodge	Toronto	40	S.T.	M. R. Laurence
		Scarborough	Scarborough	100	S.T.	A. McArthur
		Red Chevron	Toronto	174	V.C.	
		Malton (M)	Malton	500	A. & C.	R. L. King
		Dividale (*Inst.*)	Toronto	100	H. & O.	
		Toronto E. Gen. Vet. Pav.				
		Sunnybrook	Toronto	950	G. & S.T.	F. G. Charlton (District)
E	Quebec	Savard Park	Quebec	212	G. & T.	A. M. Jack (District)
		St. Charles (M)	Quebec	300		
F	London	Westminster	London	1424	G. & P.	M. I. Crossman (District)
		London (M)	London	400		
G	Winnipeg	Deer Lodge	Winnipeg	852	G. & S.T.	H. L. Wilson
		Vet. Hosp. and Home	Winnipeg	186	V.C.	I. M. Barton (District)
		Portage La Prairie (*Inst.*)	Portage La Prairie	300	H. & O.	A. M. Nicholson
H	Regina	Regina General Veterans Pav.	Regina			
		Veterans Home. (*Inst.*)	Regina			
		Brandon (M)	Brandon	275		
I	Calgary	Col. Belcher	Calgary	335	G.	K. M. Morton (District)
		Convales. Hosp.	Calgary	175	C.	S. G. MacRae
		Veterans Home (*Inst.*)	Calgary	26	V.C.	E. Hunter
J	Vancouver	Shaughnessy Hosp.	Vancouver	1036	G. & S.T.	E. M. K. Panton
		Veterans Home (*Inst.*)	Vancouver	118	V.H.	B. MacNair
		Vancouver (M)	Vancouver	400		
		Burnaby (*Inst.*)	Vancouver		H. & O.	
K	Saint John	Lancaster	Saint John, N.B.	423	G.	E. L. Dickson (District)
		Veterans Home (*Inst.*)	Saint John, N.B.		V.C.	E. Gremley
		Sussex (M)	Sussex, N.B.	250		
L	Hamilton	Hamilton (M)	Hamilton	200		
R	Edmonton	(Univ. of Alberta Mewburn Pav.)	Edmonton			
		Veterans Home (*Inst.*)	Edmonton	60	V.C.	
S	Saskatoon	Veterans Hosp.	Saskatoon	150	G.	F. H. Walker
T	Kingston	Kingston Vet. Hosp.	Kingston	235	G. & T.	I. M. Murphy
		Peterborough Vet. Hosp.	Peterborough	210	T.	M. E. Duncan

Explanation of Code letters used under Type of Service: A—active; C—convalescent; G—general; H—health; O—occupational; P—psychiatric; S.T.—special treatment; T—tuberculosis; V.C.—veterans care. (M)—Military hospitals being taken over.

The accompanying chart of treatment services hospitals and institutions gives a fairly comprehensive picture of the type of work being undertaken by the Department of Veterans Affairs across Canada.

It is to provide nursing care for the patients in these hospitals that we urge nurses to remember that Canada's war work is not yet finished and that qualified registered nurses are still needed for this very extensive post-war nursing program. Any nurse wishing to make inquiry before applying to the Civil Service Commission is welcome to visit any of the District Offices, or write to or interview the Matron-in-Chief, the two Regional Nursing Consultants, or any of the District or Hospital Matrons whose names appear in the chart. She will be instructed how to go about making application to the Civil Service Commission for employment in the nursing service of this Department.

—AGNES J. MACLEOD.

Our Teaching Laboratory

M. EDYTHE PATTERSON

THE PRISCILLA CAMPBELL NURSES' Residence, Chatham, Ontario, was officially opened in June, 1944. It was the first nurses' residence in Canada to be named after a living superintendent, and one who is still in active service—a great compliment and high tribute to nursing.

A building is beautiful if it suits the location and purpose and is a source of lasting pleasure and usefulness. In this structure we believe we have these requisites. As in the words of Lorne Pierce— "One does not merely see it with one's eye, one breathes it, one feels it." This splendid residence includes attractive and spacious living-rooms, comfortable and modern bedrooms, a carefully arranged library, and suitable recreation facilities. In this unit, also, is a lecture and demonstration room, laboratory, instructor's office, cloakroom and washrooms for teachers and students.

After two years of use, we are very well satisfied with our planning and achievement. We are especially pleased with the teaching unit, including the general laboratory, designed for use in teaching the practical nursing arts. At the same time this space is equipped for classes in the culinary arts as taught in Nutrition and Diet Therapy. The room is 27 feet by 14 feet, well-lighted and ventilated. It is designed for convenience and efficiency. At each end of the room we have a complete working unit. One end is equipped with two electric ranges, so installed as to provide working space between the ranges and a sectional sink finished

Nursing arts laboratory

Special laboratory table

in white tile. This was accurately measured, fitted, and built so that there is no waste space. Cupboards are conveniently arranged for general equipment and supplies at either end of the room. A large blackboard completes our plan for carrying on our teaching program.

In the centre of this room is the crowning glory of our laboratory. This table, in stainless steel, was designed and constructed by specialists in this particular line of equipment. It was carefully planned in every detail for convenience and efficiency. It is sixteen feet in length, three and a half feet in width, built in two sections, with an over-shelf, eight inches wide. Stainless steel drawers, five inches deep, with a removable work board over each drawer, are spaced six on each side. This takes care of the individual work space for twelve nurses. One advantage of the two sections is that either or both tables may be moved to any other location.

We think these furnishings should facilitate greatly the time and efforts of the instructors and stimulate an added interest for student nurses in the subject matter of the lesson.

Communicable Disease Nursing

What do you know about the nursing care given to patients with one or another of the communicable diseases? How many cases have you actually nursed?

Every nurse has an intelligent understanding of microbiology, immunology, and personal hygiene. Twenty years ago, she had intimate knowledge of the appearance of the patient after infection had occurred. Present-day measures have stressed the prevention of contagion to the extent that many nurses complete their training with a good knowledge of the theory of communicable disease nursing but with little experience in either the recognition of the diseases or practice in applying the appropriate techniques.

With the increased demand for public health nurses, a broader experience is both valuable and essential. Young graduates preparing to take or having just completed a course in public health nursing and who have not had training in communicable disease nursing, would be well advised to obtain some experience in contagious disease hospitals. This experience is offered to graduate nurses who are interested at the **Strathcona Hospital, Range Road, Ottawa.** Write for particulars to the Superintendent of Nurses.

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Dorothy Fowler has been transferred from the Sackville Branch to be nurse-in-charge of the Moncton Branch. *Joan Stock* has been transferred from the Ottawa staff and is acting temporarily as nurse-in-charge of the Woodstock (N.B.) Branch.

Jean Burgess has rejoined the Order following release from the R.C.A.M.C. Nursing Service, and is acting temporarily as nurse-in-charge of the Sackville Branch. *May Deane-Freeman* has rejoined the Order following release from the R.C.A.M.C. Nursing Service and is acting temporarily as nurse-in-charge of the Edmonton Branch. *Donalda Boyer* (University of Montreal public health course) has been appointed to the Lachine staff.

Elizabeth Lovegrove has resigned from the Vancouver Branch. *Katherine Weatherhead* has resigned from the Kitchener staff and has been granted leave of absence from the V.O.N. *Mary Gulley* has resigned from the Pembroke staff to be married.

STUDENT NURSES PAGE

Multiple Sclerosis

FLORENCE CHISHOLM

Student Nurse

St. Joseph's School of Nursing, Glace Bay, N.S.

THE RUSH AND BUZZ of night duty was over. How excited we were as we hurried from the dining-room! The same question arose in the mind of each of us: "What is my assignment for the month?" I was conscious of a ripple of fear as I learned of my new duties. I had a cripple to care for, along with four other patients.

My fear melted rapidly as I walked into Margaret's room next morning. As I called out, "Good morning", she cordially responded. Although suffering considerably, laughter seemed to beam in her eyes as a friendly smile greeted me. Almost instantly I became attached to her. She looked healthy enough with her flushed face and lips. However, I soon noticed an impairment in her speech—a slow, halting, scanning way of talking. She complained of general malaise and tenderness over her whole abdomen. The legs were flexed and drawn up on her abdomen and only with great force could they be separated and properly cared for. A definite tremor was noticed in her hands. She was unable to feed or wash herself. There was a noticeable curvature in her back and there was some oscillation of the eyeballs.

I was now very curious. On referring to previous charts I learned that her illness was long-standing. In 1931, Margaret had had some trouble with her eyes, her vision being double. This was treated and she started wearing glasses. Soon afterward, she began having attacks during which the right leg would become rigid, sometimes causing her to fall down. Both limbs became heavy and weak, attended by some numbness, itching and "jumping of nerves." Eventually, the numbness and weakness of her legs caused a fall which resulted in a fracture of the right tibia and fibula.

On November 5, 1941, Margaret was admitted to hospital. A plaster cast was applied extending from the toes to above the knee. She was discharged on November 22, 1941, and remained home until February 6, 1942. On removing the cast, it was found that her leg flexed at right angles and she was unable to extend it voluntarily or by force. However, the doctor was determined to assist this courageous girl. Her right leg was extended, under anesthetic, and a plaster cast was again applied. Margaret was discharged on April 6, 1942, with the hope of a speedy recovery.

It was found, on re-admission to the hospital a few months later, that the nervous system was involved. Margaret had Argyll-Robertson pupils, bilateral positive Babinski, nystagmus, spastic paresis of both limbs, and poor abdominal reflexes. No disturbance of sensations was detected. Examination of the blood revealed a negative Kahn. There was a noticeable spasm of both adductor and flexor muscles at the hip and knees. The right leg could be ex-

tended with great difficulty for a short time. The cast seemed to aggravate the condition.

Following a consultation on September 19, 1942, the doctors decided to operate. After the customary preparation, Margaret was taken to the operating-room. An incision was made along the course of the sciatic nerve. The nerve was exposed and injected with pure alcohol.

Margaret made a good recovery following operation, with the exception of some pain in the operative area. Luminal gr. 1½ was given at night with further sedation if necessary. Diathermy treatment was started but there was little or no response. On October 28, 1942, Margaret was discharged. She remained at home for approximately two years. During this time her mother had been her nurse. Great difficulty was experienced in bathing her and moving her in the bed, due to the flexed limbs. She also had pain and discomfort caused by the pressure of the distorted limbs one on the other. Atrophy of the muscles in her legs was observed.

Margaret's condition had not improved but on the contrary was gradually growing worse. This was not a surprise to the doctors, as they knew that the prognosis is always unfavorable in multiple sclerosis. Margaret, too, knew that she could not be cured. Very few of this world's consolations remained to her. Because her eyes were involved, she could read practically nothing. Needlework was denied her because her hands were so unsteady. She could not even sit up. It was apparent that in order to have her a happy patient, a genuine effort must be made to help her in addition to the routine nursing care she received. We endeavored to give all the help we could by reading to her, conversing with her, and re-assuring her. She was given a daily bath with special care to her back and buttocks; frequent changes of position made her more comfortable. Her limbs were massaged with oil three times each day. Occasionally, external heat (hot water bottles at 120° F.) afforded some relief.

Much of Margaret's discomfort was due to the pressure of one leg on the other, resulting from the contracted muscles. The doctors decided that if the adductor muscles were cut, it would at least afford temporary relief by lessening the rigidity and pressure. She was admitted again to the hospital to be prepared for a second operation. Under general anesthetic, a transverse incision was made above the pubes. The obturator nerve was hooked up on either side and the nerve severed. All of the adductor muscles were cut at their insertion in the pubes. Although enduring great pain, Margaret appeared to make a favorable recovery following the operation. Her legs seemed less rigid and she enjoyed a less interrupted sleep during the night. Mentally and physically, a slight improvement could be noted.

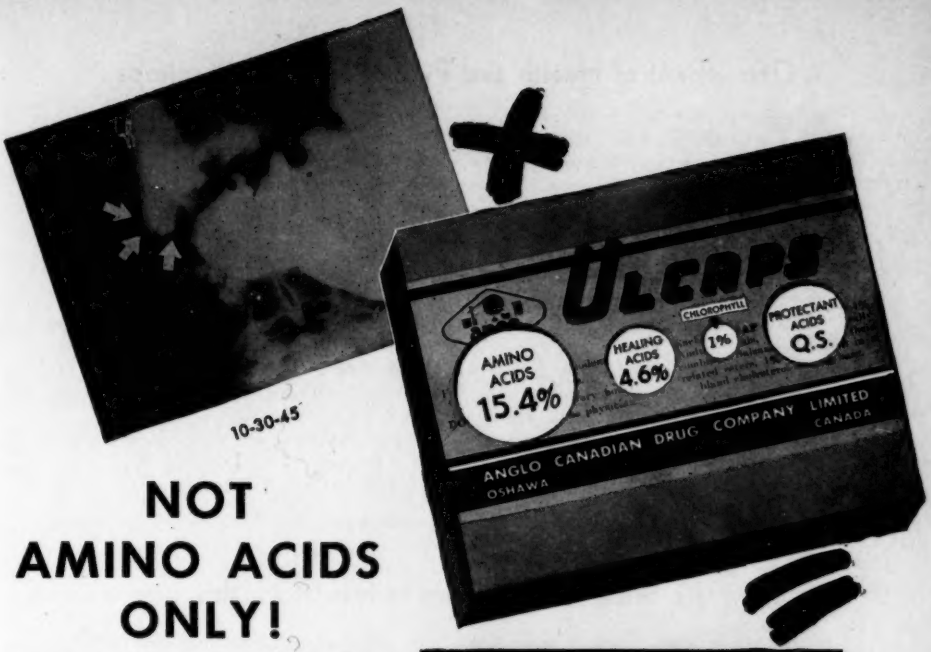
On May 16, 1945, Margaret was discharged from the hospital still cheerful and courageous, yet conscious of the fact that she would never again walk. On visiting her sometime afterwards, I found her contented and resting fairly well.

In conclusion, I have learned from this patient:

To take more interest in the diagnosis, the symptoms, the complications, and the palliative treatment of incurable cases; the importance of cheerful nursing to an incurable invalid; the effect of nerve blocking; and lastly, respect for the patient's acceptance of a great physical tragedy at a youthful age.

Preview

Many years ago now, the Canadian Nurses Association went on record as favoring the eight-hour day for nurses. Despite this accord, many hospitals have not succeeded in putting this system into practice. B. Orlo MacInnes has outlined for us how their plan works at the Children's Memorial Hospital in Montreal.

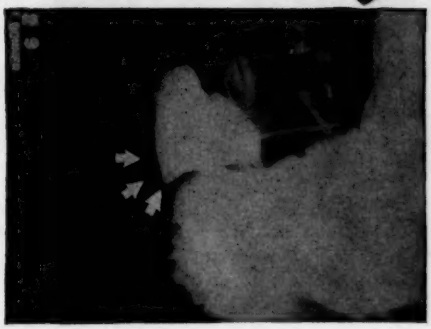


NOT AMINO ACIDS ONLY!

More than two years of clinical investigation, substantiated by roentgenologic evidence, has convinced us that the sole use of the Amino Acids in peptic ulcer therapy is not sufficient.

We believe that:

1. *The Ulcer should be protected from gastric juice.*
2. *The healing of the lesion should be stimulated.*
3. *Nutrition should be enhanced.*



11-29-45

The initial dose of Ulcaps is: One every waking hour.

Please write for further information and a clinical trial package.

100 PER CENT CANADIAN

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OSHAWA CANADA

MANUFACTURERS OF FINE PHARMACEUTICALS

Department of Health and Public Welfare, Manitoba

Sixty-eight public health nurses are on the Provincial Public Health Nursing Staff, but twenty more are urgently needed for new Health Units which will be opened as soon as personnel are available. Health Units recently opened are: Portage La Prairie, Selkirk, Red River, Swan Valley.

Six students, who are taking the public health course at the University of Manitoba, are receiving field experience with the Department.

The following returned nursing sisters have joined the staff: *D. Ambrose, E. M. Crichton, E. Elder, P. M. Hadland, L. Regnier, A. Story. Beth Rice-Jones*, who was on leave of absence, has returned and is now with the Brandon Health Unit. *Peggy Hart*, who received her M.A. degree, and *Phyllis Hammond*, who received her B.Sc. degree, have recently returned to the staff from Columbia University.

The following nurses are on leave of absence: *M. McLeod, B. Warbanski*, attending University of Manitoba; *Lillian Blair*, attending University of Minnesota; *Frances King, Edith McDowell*, attending Columbia University; *Betty Brown, A. Cran*, attending McGill University. *J. deBrincat*, on leave of absence with UNRRA, has been transferred from South to North Italy.

Claire Hough recently resigned to be married in England.

The Student Nurse and Industrial Health

Suggestions of ways by which industrial public health nursing can be integrated into the basic nursing curriculum are made by the Bureau of Public Health Nursing as follows:

1. The student nurse can be taught to recognize the student health program in her school of nursing as an industrial health program, to regard accidents and illness incurred while in training as industrial injuries and sickness, and to know the liabilities and responsibilities of hospital management and employees, including the nurse herself.

2. The student nurse who cares for patients suffering from industrial accidents and illness can be taught to recognize these as "errors" in industry and to inquire into the history of the injury or sickness, possible methods of prevention, and health and safety programs in the plants.

3. The student nurse can study the compensation laws and can be given an understanding of the cost of industrial accidents and illness to management, employees, and the community.

Institute at Sydney

A short course in Supervision was held in Sydney, N.S., on the afternoons and evenings of April 3, 4, and 5, 1946. The course was conducted by highly-qualified local nurses, including Rhoda F. MacDonald and Jemima MacLean. The program included papers on such topics as: the supervisor as a nurse, teacher, and administrator; methods of ward teaching; efficiency rating of students; supervisor's part in in-service education, etc.

There was an attendance of sixty-three, consisting largely of young head nurses who had recently taken over positions in local hospitals.

Preview

Comes summertime and vacations and, one and all, we yearn for the simple life of camp. Children by the thousands go to camps all over Canada. With them, as their safeguard and friend, go nurses—some experienced in camp-lore, some admitted novices. For the oldtimers, **Elizabeth K. McCann's** description of the role of the camp nurse, will bring a nostalgic longing to spend a few weeks away from the routine duties. To the beginners, she gives many useful hints on how to make the nurse's routines fit into the camper's program. Be sure to read this useful yet amusing account.

Urgent Need for Nurses in Northern India

In the District of Kangra, North India, Canadian nurses are urgently needed for the three hospitals of the Church of England in Canada.

In this vast district of ten thousand square miles, lying among the foothills of the Himalayas, dwell nearly a million Hindus and Mohammedans. These three hospitals are the only centres in which the skill of doctors and nurses is used, not only in easing the burden of suffering, but in supplanting superstition, ignorance, and fear by knowledge of the Christian way of life.

St. Luke's Hospital, Palampur, and the Maple Leaf Hospital, in the town of Kangra, although they can boast a total of only eighty to eighty-five beds, are rendering outstanding service among the women and children of the communities, particularly through their maternity work and instruction in child care. *Nursing Superintendents are needed for both these hospitals.*

The Lady Willingdon Hospital, the spearhead of new work in the Kulu Valley, requires a married doctor and a Canadian nurse.

Further information about these opportunities may be obtained from the **Dominion Candidates' Secretary of the Woman's Auxiliary, Mrs. Leslie Hunt, 69 High Park Blvd., Toronto 3, Ontario.**

M.L.I.C. Nursing Service

The following are recent changes in personnel of the Metropolitan Life Insurance Company Nursing Service:

Cecile Bonnier (Hotel Dieu Hospital, Montreal, and University of Montreal public health course) has resigned from the Montreal staff and the Company's service.

Rita Chamberland (St. Sacrement Hospital, Quebec City), *Catharine Lamarre*, and *Jeannette Sylvain* (l'Enfant Jesus Hospital, Quebec City) have been transferred from Montreal to the Quebec City nursing staff. *Gilberte Patry* (Notre Dame Hospital, Montreal, and University of Montreal public health course) was transferred recently from Quebec City to take charge of the Company's service in Valleyfield, P.Q.

News Notes

ALBERTA

EDMONTON:

Royal Alexandra Hospital:

The largest graduating class in the history of the Royal Alexandra Hospital School of Nursing was recently entertained at the twentieth annual banquet held by the alumnae association. There are sixty-four graduates in the 1946 class with four affiliate nurses at the Provincial Mental Hospital, Ponoka.

The nurses, gowned in formal evening frocks, were seated at tables for six, decorated with spring flowers and place cards painted by Violet Chapman, president of the alumnae, who presided at the banquet.

Seated at the head table were Mr. W. Stanley Ross, an Edmonton lawyer, who was guest speaker, and Mrs. Ross; Mmes J. Richardson, W. Norquay, H. Brennan, F. J. Thompson, T. M. Blacklock, Misses M. Fraser, V. Chapman, A. Swift, M. Griffith, and K. Ford.

Mrs. Norquay proposed the toast to the King; Mrs. Blacklock proposed the toast to Our Alma Mater; Miss Swift gave the toast to the graduating class and Mrs. J. Johnston responded. The Choral Club, under the direction of Arthur Newcombe, sang several songs and Marjorie Nelson entertained with piano selections.

At a recent regular meeting of the alumnae association, with V. Chapman presiding, there were forty-five members present. Reports from standing and special committees were received and a vote of thanks was tendered to the banquet committee, which consisted of Joan Gardiner, Anne Young, Margery Edgar, and Jean Noble, for their splendid work.

Dr. H. Richard was the guest speaker and he told of his experiences overseas with the R.C.A.M.C. in Italy, Sicily, and Holland. Anne Swift extended the vote of thanks.

BRITISH COLUMBIA

Janie Jamieson was elected president of the Greater Vancouver District Association, R.N.A.B.C., at its recent annual meeting. Other officers include: vice-president, P. Capelle; secretary, P. Rowe; treasurer, Mrs. L. E. Jones; section chairmen: hospital and school of nursing, Sr. Priscilla Marie; general nursing, E. Huntley; public health, C. Charter; councillors, F. Rowell, E. Gilmour, I. Goward.

Dr. C. H. Gundry, director of the School Health Services, Metropolitan Health Committee, spoke on "A Verification of Some Principles of Mental Hygiene with Reference to Military Experience."

Trail-Tadanac Hospital:

Helen Greaves, Erma Rankin, and Lois Smith, all of the Brockville General Hospital,

have resigned from the staff and are returning to the east after one year in Trail. Erma Keller will be on duty at Banff Hospital for the summer and will enter U.B.C. in the fall. Helen Reederer, from the Holy Family Hospital, Prince Albert, Sask., has been added to the staff.

NOVA SCOTIA

NEW GLASGOW:

Aberdeen Hospital:

At a recent meeting of the alumnae association, held at the home of Mrs. Max Fraser, the association voted $10 to help fill boxes to be sent to nurses in the Netherlands. A number of garments have also been made for use by the V.O.N. nurses in their work.

N/S Beryl Ripley, of River Philip, has recently returned from overseas. Florence Marshe, of New Waterford, is taking a post-graduate course at St. Michael's Hospital, Toronto.

ONTARIO

EDITOR'S NOTE: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

DISTRICTS 2 AND 3

GALT:

At a recent meeting of the Galt Hospital Alumnae Association, conducted by the president, Hazel Blagden, the members were privileged to hear Helen Elliott who told of her interesting experiences as a nurse in northern Ontario and Kapuskasing. Patsy Byrne contributed a piano solo.

DISTRICT 4

HAMILTON:

A regular meeting of Hamilton Chapter, District 4, R.N.A.O., was held recently at St. Joseph's Hospital, with M. Blackwood presiding. Nancy Wilson from New Zealand was the guest speaker and gave an interesting description of the various activities of the nursing organizations and nursing fields. Viola Jennings, convener of food parcels for the nurses in Holland, told of the hearty response to the appeal for sending parcels weekly. Two more names were added to the list. The Hospital and School of Nursing Section reported the formation of a Journal Club. A social hour followed.

Ellen E. Ewart, who has served with the R.C.A.M.C. overseas, has returned to her former position as superintendent of nurses, Mountain Sanatorium.

NIAGARA FALLS:

At a regular meeting of the Niagara Peninsula Chapter, District 4, R.N.A.O., held at the General Hospital, Stella Murray

was in the chair. Reports were heard from the various committees. Parcels are being sent weekly to the nurse in the Netherlands. It was decided to also send parcels to one or more selected British nurses and arrangements are to be made through the C.N.A.

The guest speaker of the evening was Ada Scheifele, chairman of District 4. Miss Scheifele is also superintendent of Mount Hamilton Hospital and has seen service as a medical missionary in China. Miss Scheifele addressed the meeting on the organization, activities, and services of the R.N.A.O., such as the legal services and publicity program being developed. She spoke of the eighteen new community nurses' registries organized throughout the province and of the revision of the Constitution. Mary Smith sang a group of Irish airs accompanied by Mrs. E. Parker. Refreshments were served by the nursing staff of the General Hospital.

DISTRICT 5

The annual meeting of District 5, R.N.A.O., was recently held in Toronto with the chairman, Claribel McCorquodale, presiding. The guest speaker, Mildred Walker, chief of the Division of Study for Graduate Nurses, Institute of Public Health, University of Western Ontario, chose as her topic, "The Evaluation of the Nurse."

The evening session took the form of a banquet at which the guest speaker, Dr. Edward Hall, Dean of the Faculty of Medicine, and president-elect of the University of Western Ontario, outlined the new medical course at the university. About five hundred nurses attended, including a large number of nursing sisters and student nurses. Tribute was paid to the retiring secretary-treasurer, Mrs. G. L. Williamson.

The officers elected were: chairman, C. McCorquodale; vice-chairmen, J. Wallace, H. Bennett; section conveners: public health, B. Abernethy; general nursing, L. Rutherford; hospitals and schools of nursing, L. Lambe; councillors, G. Jones, M. Winter, F. Fell, H. Nightingale, E. Hill, O. Brown. The new secretary-treasurer is Mrs. Kathleen McIntosh.

DISTRICT 6

BELLEVILLE:

The following officers have recently been elected to serve for Chapter A, District 6, R.N.A.O.: chairman, T. Gordon; vice-chairmen, M. Gist, D. Senn; secretary-treasurer, M. Rutherford; committees: membership, E. Horton; nursing education, M. Davidson; program, M. Byers, G. Donnelly, Mrs. MacMillan; representatives for: private duty nursing, Mrs. I. Barriage; *The Canadian Nurse*, Miss E. Jack.

PETERBOROUGH:

At a recent meeting of Chapter C, District 6, R.N.A.O., with Mary Ross presiding, there were thirty-six members present. Miss Lawless, reporting for the hospital and school of nursing section, told of the refresher course she had attended at the Institute of Public Health, London. The public health section reported that student nurses from St. Joseph's Hospital will spend a day with the Public Health Department.

Dr. John Epping spoke on "Oxygen Therapy" and Mr. Staples told the members something about its history. Mr. Dover showed a film on the different types of appliances, tents, etc.

At a later meeting it was revealed that the total bank balance was $230.10. The report of the hospital and school of nursing section was concerned with the submitting of techniques for bed bath and morning and evening care in hospitals. The program consisted of a discussion on new drugs, presented by Shirley Beer.

DISTRICT 8

At a recent meeting of District 8, R.N.A.O., sponsored by the public health section, the subject, "Industrial Nursing", was discussed. The guest speakers were Dr. F. S. Parney and Frances Harris of the Department of Health and Welfare. Dr. Parney spoke on the health problems in industry and Miss Harris on the nurse in industry.

Annette Landon, speaking for the private duty nurse going directly into industry, stated that, in a recent survey among the nurses, the general concensus was that they should have had the basic preliminary course in public health. Some felt that they should have additional training in nutrition, mental hygiene, and first aid, while others felt that their experience, plus an aptitude for dealing with people, was sufficient.

As a result of this meeting a motion was sent to the R.N.A.O. recommending that the official nursing organization approach management or the heads of industry to facilitate the training of public health nurses in industrial nursing, both in field work and with financial aid.

QUEBEC

MONTREAL:

Children's Memorial Hospital:

The Staff Association was very pleased to have again, as their guest speaker, Margaret

Kerr, who concluded her subject, "A Nurse's Role in Sex Education", for the educational program.

Plans were made for a Spring Formal, with M. Uyede as convener, for the purpose of raising funds to send a representative to the C.N.A. convention.

Dorothea Keith, of the Saskatoon City Hospital, has joined the operating-room staff, replacing Catherine Hodgins who resigned.

Montreal General Hospital:

The Student Government Association was recently addressed by Mrs. John O'Neill Gallery on behalf of the "Save the Children Fund." Several teas have been sponsored this past winter by the student nurses, the proceeds of which have been donated to this fund.

Recent guest speakers at the monthly alumnae association meetings have been Dr. G. A. Hurley and Dr. Stuart Townsend. Dr. Hurley gave an instructive talk on "Nursing Care in Chest Surgery" and Dr. S. Townsend spoke on "Aviation Medicine."

Miss Kennedy-Reid, who went overseas as assistant matron to Dorothy MacRae, No. 1 Canadian General Hospital, has now been appointed by the Department of Veterans Affairs to the post of matron-in-charge of the nursing personnel at Ste. Anne de Bellevue Military Hospital.

B. M. MacMurchy, on furlough from the Canadian Presbyterian Mission, Jabot, Central India, recently spent a few days at the hospital where she attended the clinics and addressed the student nurses. Elizabeth H. Colley, sister-in-charge of the children's ward, recently spent ten days at the Hospital for Sick Children, Toronto.

Joan Dorning recently joined the staff after her release from the R.C.A.M.C. T. M. McCullough, who has returned from duty overseas, is now on the night staff. Hazel Chalmers, Janet Muff, and Mrs. Anne Fawthrop have retired from the staff.

The members of the graduating class will be entertained at a dinner, previous to graduation, by the alumnae association.

Royal Victoria Hospital:

N/S Mildred Goodill has recently returned from overseas, having spent four years in South Africa and the Middle East. Mrs. Allan (Hamilton) Kaye is also back in Canada, having spent the past eight years in England. She will reside in Three Rivers, P.Q.

Mrs. Thomas, who has resigned her position as supervisor of the outdoor department, has been replaced by Rita Ackhurst. Mary Warnock, of the operating-room staff, is observing in the operating-room, Massachusetts General Hospital. M. Keith and Miss Badenoch are now on the staff of the King Edward VII Memorial Hospital, Bermuda. E. Martin is clinical instructor at the Calgary General Hospital.

QUEBEC CITY:

Jeffery Hale's Hospital:

Capt. R. B. Rabinovitch, R.C.A.M.C., psychiatrist of the Quebec Military Hospital, was the guest speaker at a recent alumnae association meeting. Introduced by M. Fischer, president of the alumnae, Dr. Rabino-

vitch pointed out that a person's behavior is the result of his basic tendencies and his environmental influences:

"We know more today about the environment aspect than we do about the inherent or unchangeable side, and there are many factors in development that we can control. People are of varying types and all are not born with equal potentialities for accomplishment, but this does not mean that those with lesser endowment should not adjust themselves as well as their more gifted brothers.

"We have learned many important principles of interpersonal relations. Perhaps most important of all is that bad children, bad husbands and wives, bad bosses and workers, and criminals, too, are not born—they are made. In many cases they are products of social forces gone wrong. Children are born with a bundle of potentialities waiting to be developed, and no matter what these potentialities may be, they will not just sprout out, they have to be developed, and we often fail miserably in this direction."

SASKATCHEWAN

MAPLE CREEK:

Mrs. W. S. (Clarke) Drader was recently entertained at a miscellaneous shower in the nurses' home when an enjoyable evening was spent. A hearty welcome is extended to Mrs. Wm. (Woodward) Horley and Mrs. Wm. G. (Stewart) Hurlow, as well as to Mrs. Drader, who are now residing in Maple Creek.

MOOSE JAW:

Plans are underway at the General Hospital for the Doctors' Dance which is held every year in honor of the graduating class. Mrs. M. Fyrk is relieving in the office of the General Hospital for Patricia MacKenzie who is on vacation in Vancouver. Mrs. Alta Tait has returned from a visit in Regina. Rev. Sr. M. Desmond has recently returned from the east and is now on the operating-room staff at the Providence Hospital.

PRINCE ALBERT:

At a recent meeting of the Catholic Graduate Nurses' Association, held at the Holy Family Hospital, the president, Noreen Lambert, was in the chair. Reports on the silver tea and on the finances of the organization were given by the secretary-treasurer. Frances Altmann was appointed as the convener in charge of arrangements for the entertainment of the graduating class. Rev. Father Sexsmith, of Saskatoon, gave an interesting talk on "Faith and What it Means to Members of the Nursing Profession," and a social hour followed.

WEYBURN:

The Weyburn Chapter is continuing to send parcels of food to a nurse in Holland.

Misses Buckingham and Paton, formerly on the Weyburn General Hospital staff, and now at Deer Lodge Hospital, Winnipeg, recently paid a visit to their home at Yellowgrass. M. Biggs, of Kingston, Ont., and R. Naemark, of Estevan, are now on the staff of the Weyburn Mental Hospital.

Nutritional Effect of Mineral Oil

The habitual use of mineral oil is so widespread and may have such serious nutritional consequences that an excerpt from an article by Dr. Norman Jolliffe in a recent issue of *Nutrition Notes* is reprinted here. Dr. Jolliffe is associate professor of medicine, New York University School of Medicine, and lecturer in public health practice, College of Physicians and Surgeons, Columbia University:

"Mineral oil is one of the most commonly used laxatives, although warnings have been given frequently about the harmful effect that it has on the utilization of carotene, the provitamin A, a very important nutritional factor. Most, if not all, of the carotene in green and yellow vegetables and fruits, which the body normally converts into vitamin A, may be absorbed by the mineral oil and eliminated unused by the oil. Since most people get a large part of their vitamin A requirements in the form of carotene, users of mineral oil may, therefore, be deprived of the many benefits of this vitamin. When mineral oil is used over a long period of time, real harm may result. This absorption of the vitamins by the mineral oil may take place even when the vegetables or fruits are eaten at dinner and the mineral oil is taken at bedtime.

"Recent experiments show that mineral oil interferes also with the utilization of other essential food factors, especially vitamin D and the minerals, calcium and phosphorus, which are necessary for building good bone and tooth structure, and vitamin K, which helps to assure proper coagulation of the blood, especially after childbirth. Since these are factors that are very important in the diet during pregnancy to ensure health protection for the mother and the best growth of the coming baby, it seems inappropriate that mineral oil should be used so commonly by pregnant women.

"In reducing diets, where calories must be kept low, mineral oil is sometimes suggested as an ingredient for salad dressing or mayonnaise since the mineral oil provides no food value, whereas salad oil dressings add considerably to the caloric content of the diet. A mineral oil dressing, however, deprives the body of the carotene of the various kinds of vegetables which are used in salads.

"The wartime shortage of oil, lard, and other fats has led some food manufacturers to use mineral oil in salad dressings and for frying salted nuts, potato chips, and doughnuts for sale to consumers. Such practices may have serious nutritional consequences, and housewives should read the labels on the containers of such products to assure themselves that mineral oil has not been used.

"Because mineral oil is so widely used, it seems apparent that many people have not realized these harmful effects it may have. The harm may far outweigh its advantages. Certainly, it should never be taken except on the specific recommendation of a physician."

Nutrition Notes

The quantity of vitamin C available in rose hips is sufficient to warrant their addition to various foods in the course of preparation. Soups, sherbets, juices, jellies, and jams are all suggested as useful mediums through which the rose hips may be utilized.

There is a much smaller loss of the riboflavin content in chocolate milk than in whole milk when they are exposed to sunlight for an equal length of time.

Obituaries

Mrs. N. H. (Hanson) Hamilton, a graduate in 1930 of The Montreal General Hospital, died in Montreal on April 6, 1946.

Laura M. Longmoore, a graduate of Jeffery Hale's Hospital, Quebec, died in Montreal on March 13, 1946.

Maria MacCallum, who graduated in 1916 from The Montreal General Hospital, died, in Montreal, on March 22, 1946, after a protracted illness.

Eileen Teresa McAleenan, an intermediate student at St. Joseph's Hospital, Saint John, N.B., passed away suddenly on March 7, 1946.

Mrs. Olive (Alford) McCullogh, a graduate in 1925 of The Montreal General Hospital, died on April 9, 1946.

Mrs. Edith Muriel (Patton) Rice, a graduate of the Toronto General Hospital, died on March 31, 1946, in Los Angeles.

WANTED

A **Classroom Instructress** is required for a 75-bed hospital. The salary is $125 and full maintenance. Apply to:

Supt. of Nurses, Lamont Public Hospital, Lamont, Alta.

WANTED

A **Therapeutic Dietitian** is required for the **University of Alberta Hospital, Edmonton.** REQUIREMENTS: University Degree; post-graduate course in Dietetics and two years' experience. The minimum salary is $110 per month, plus meals and laundry. Apply to:

Director of Dietetics, University of Alberta Hospital, Edmonton, Alta.

WANTED

Applications are invited for the position of **Director of Nursing Service** and **Principal of the School of Nursing** at the **Peterborough Civic Hospital.** Program of expansion provides for an entirely new hospital and School of Nursing. Apply, stating qualifications, to the:

Secretary, Board of Governors, Peterborough Civic Hospital, Peterborough, Ont.

WANTED

An **Operating Room Nurse** and **Floor Duty Nurses** are required. Apply, with references, to:

Supt., Barrie Memorial Hospital, Ormstown, P.Q.

WANTED

A **Night Supervisor** is required for a 50-bed Maternity Hospital. Apply, stating qualifications, salary, etc., to:

Supt., Catherine Booth Mothers' Hospital, 4400 Walkley Ave., Montreal 28, P.Q.

WANTED

An **Assistant Classroom Instructress** is required for a 118-bed hospital (with immediate prospects of construction of 150-bed modern hospital). Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Sherbrooke Hospital, Sherbrooke, P.Q.

WANTED

Saskatchewan Canadian Red Cross Society desires applications from nurses for Charge Work and Staff Duty for Outpost Hospitals in Northern Saskatchewan. Attractive salaries; full maintenance; one month's holiday. Apply, stating full particulars, to:

Supervisor of Nursing, Canadian Red Cross Society, Saskatchewan Division, 2331 Victoria Ave., Regina, Sask.

WANTED

Vancouver General Hospital desires applications from Registered Nurses for **General Duty.** State in first letter date of graduation, experience, references, etc., and when services would be available.

Eight-hour day and six-day week. Salary: $95 per month living out, plus $19.92 Cost of Living Bonus, plus laundry. One and one-half days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. One month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to:

Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital, Vancouver, B.C.

WANTED

A qualified **Instructress** is required for a small Training School by **August 1, 1946.** Apply, stating qualifications and salary expected, to:

Superintendent, Chipman Memorial Hospital, St. Stephen, N.B.

WANTED

A **Matron** is required for a 20-bed hospital at **Vita, Manitoba,** operated by United Church of Canada. Resident medical superintendent and assistant; graduate nursing staff. Apply to:

Rev. J. A. Cormie, 441 Somerset Bldg., Winnipeg, Man.

WANTED

General Duty Nurses are required at a salary of $90 per month; $100 for permanent Night Duty—plus full maintenance. The hospital is situated in a healthful and beautiful location; 55 miles from Montreal, 10 miles from Brome Lake. Bus service daily. Apply to:

Superintendent, Brome-Missisquoi-Perkins Hospital, Sweetsburg, P.Q.

WANTED

Applications are invited for the position of **Clinical Instructor.** Position open on **August 1.** Apply, stating qualifications, experience, and salary expected, to:

Supt. of Nurses, McKellar General Hospital, Fort William, Ont.

WANTED

A **Night Supervisor** is required immediately for a 65-bed hospital at a salary of $110 per month. A **Dietitian,** preferably with previous experience, is also required at a salary of $100 per month. **Floor Duty Nurses** are needed at a salary of $100 per month. 6-day week; holidays with pay; full maintenance. Apply to:

Superintendent, Lady Minto Hospital, Cochrane, Ont.

WANTED

Verdun Protestant Hospital requires for immediate service: (a) **Assistant Director of Nursing;** (b) fully-qualified **Instructor;** (c) **Ward Supervisors;** (d) **General Staff** nurses. Applications are invited from Registered Nurses, stating in first letter date of graduation, qualifications, experience, and when services would be available. Apply to:

Director of Nursing, Verdun Protestant Hospital, Box 6034, Verdun, P.Q.

Official Directory

THE CANADIAN NURSES ASSOCIATION

1411 Crescent St., Montreal 25, P.Q.

President	Miss Fanny Munroe, Royal Victoria Hospital, Montreal 2, P.Q.
Past President	Miss Marion Lindeburgh, 3466 University Street, Montreal 2, P.Q.
First Vice-President	Miss Rae Chittick, Faculty of Education, University of Alberta, Calgary, Alta.
Second Vice-President	Miss Ethel Cryderman, 281 Sherbourne Street, Toronto, Ont.
Honourary Secretary	Miss Evelyn Mallory, University of British Columbia, Vancouver, B.C.
Honourary Treasurer	Miss Marjorie Jenkins, Children's Hospital, Halifax, N.S.

COUNCILLORS AND OTHER MEMBERS OF EXECUTIVE COMMITTEE

Numerals indicate office held: (1) President, Provincial Nurses Association; (2) Chairman, Hospital and School of Nursing Section; (3) Chairman, Public Health Section; (4) Chairman, General Nursing Section.

Alberta: (1) Miss B. A. Beattie, Provincial Mental Hospital, Ponoka; (2) Miss A. M. Anderson, Royal Alexandra Hospital, Edmonton; (3) Miss E. I. Stewart, Health District, High River; (4) Mrs. B. Kipp, Galt Hospital, Lethbridge.

British Columbia: (1) Miss E. Mallory, University of B.C., Vancouver; (2) Miss E. Davis, Ste. 22, 1311 Beach Ave., Vancouver; (3) Miss P. Reeve, 3137 W. 42nd Ave., Vancouver; (4) Miss E. Otterbine, Ste. 5, 1334 Nicola St., Vancouver.

Manitoba: (1) Miss B. Seeman, Winnipeg General Hospital; (2) Mrs. H. Copeland, Misericordia Hospital, Winnipeg; (3) Miss W. Barratt, 3 Woodrow Aparts., Winnipeg; (4) Miss Jean McPhail, 859 Bannantyne Ave., Winnipeg.

New Brunswick: (1) Miss M. Myers, Saint John General Hospital; (2) Miss M. Murdoch, Saint John General Hospital; (3) Miss M. Hunter, Dept. of Health, Fredericton; (4) Mrs. H. Smith, 57 Queen St., Moncton.

Nova Scotia: (1) Miss R. MacDonald, City of Sydney Hospital; (2) Sister Catherine Gerard, Halifax Infirmary; (3) Miss M. Ross, V.O.N., Pictou; (4) Miss M. MacPhail, 29 St. Peter's Rd., Sydney.

Ontario: (1) Miss Jean I. Masten, Hospital for Sick Children, Toronto 2; (2) Miss E. Young, Peterborough Civic Hospital; (3) Miss S. Wallace, Division of Industrial Hygiene, Parliament Bldgs., Toronto 2; (4) Miss K. Layton, 341 Sherbourne St., Toronto 2.

Prince Edward Island: (1) Miss D. Cox, 101 Weymouth St., Charlottetown; (2) Sr. M. Irene, Charlottetown Hospital; (3) Miss S. Newson, Junior Red Cross, Charlottetown; (4) Miss M. Lannigan, Charlottetown Hospital.

Quebec: (1) Miss E. Flanagan, 3801 University St., Montreal 2; (2) Rev. Sr. Denise Lefebvre, Institut Marguerite d'Youville, 1185 St. Matthew St., Montreal 25; (3) Miss A. Girard, l'Ecole d'infirmières hygiénistes, University of Montreal, 2900 Mt. Royal Blvd., Montreal 26; (4) Miss E. Killins, 1230 Bishop St., Montreal 25.

Saskatchewan: (1) Mrs. D. Harrison, Experimental Station, Swift Current; (2) Miss A. Ralph, Moose Jaw General Hospital; (3) Miss E. Smith, Dept. of Public Health, Parliament Bldgs., Regina; (4) Mrs. V. M. McCrory, 409-19th St. E., Prince Albert.

Chairmen, National Sections: Hospital and Schoo of Nursing: Rev. Sister Clermont, St. Boniface Hospital, Man. Public Health: Miss Helen McArthur, 218 Administration Bldg., Edmonton, Alta. General Nursing: Miss Pearl Brownell, 212 Balmoral St., Winnipeg, Man. Convener, Committee on Nursing Education: Miss E. K. Russell, 7 Queen's Park, Toronto 5, Ont.

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Registered Nurses Ass'n of Ontario: Miss Matilda E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 5.

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Registered Nurses Ass'n of the Province of Quebec: Miss E. Frances Upton, 1012 Medical Arts Bldg., Montreal 25.

Saskatchewan Registered Nurses Ass'n: Miss Kathleen W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

Provincial Associations of Registered Nurses

ALBERTA

Alberta Association of Registered Nurses

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Ponoka District, No. 2, A.A.R.N.

Pres., Miss Phyllis Fraser; Vice-Pres., Miss Doris Smith; Sec.-Treas., Miss Elizabeth Robertson, Provincial Mental Hospital, Ponoka; Representative to *The Canadian Nurse*, Miss Nessa Leckie.

Calgary District, No. 3, A.A.R.N.

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Medicine Hat District, No. 4, A.A.R.N.

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Lethbridge District, No. 8, A.A.R.N.

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BRITISH COLUMBIA

Registered Nurses Association of British Columbia

Pres., Miss E. Mallory, University of B.C., Vancouver; Vice-Pres., Misses E. Palliser, E. Clark; Hon. Sec., Miss E. Paulson; Hon. Treas., Mrs. E. Pringle; Past Pres., Miss G. Fairley; *Section Chairmen: General Nursing*, Miss E. Otterbine, Ste. 5, 1334 Nicola St., Vancouver; *Hospital & School of Nursing*, Miss E. Davis, Ste. 22, 1311 Beach Ave., Vancouver; *Public Health*, Miss P. Reeve, 3137 W. 42nd Ave., Vancouver; *District Councillors: Central Interior*, Mrs. M. Brolin; *East Kootenay*, Mrs. E. Kelman; *Fraser Valley*, Miss M. Hamilton; *Greater Vancouver*, Misses E. Gilmour, I. Goward, F. Rowell; *Kamloops-Okanagan*, Miss O. Garrood; *Vancouver Island*, Misses M. Fletcher, S. Porritt; *West Kootenay*, Miss A. K. Williams; Director, Placement Service, Miss Elizabeth Braund, 1001 Vancouver Block, Vancouver; Executive Secretary & Registrar, Miss Alice L. Wright, 1014 Vancouver Block, Vancouver.

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Manitoba Association of Registered Nurses

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PRINCE EDWARD ISLAND

Prince Edward Island Registered Nurses Association

Pres., Miss Dorothy Cox, 101 Weymouth St., Charlottetown; Vice-Pres., Miss Mildred Thompson,

P. E. I. Hospital, Charlottetown; Sec., Miss Helen Arsenault, Provincial Sanatorium, Charlottetown; Treas. & Registrar, Sr. M. Magdalen, Charlottetown Hospital; *Section Chairmen: Public Health*, Miss Sophie Newson, Junior Red Cross, Charlottetown; *Hospital & School of Nursing*, Sr. M. Irene, Charlottetown Hospital; *General Nursing*, Miss Mary Lannigan, Charlottetown Hospital.

QUEBEC

Registered Nurses Association of the Province of Quebec (Incorporated 1920)

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SASKATCHEWAN

Saskatchewan Registered Nurses Association (Incorporated 1917)

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Alumnae Associations

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A.A., Calgary General Hospital

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A.A., Holy Cross Hospital, Calgary

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A.A., Edmonton General Hospital

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A.A., Misericordia Hospital, Edmonton

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A.A., Royal Jubilee Hospital, Victoria

Pres., Miss R. Kirkendale; Vice-Pres., Miss P. Barbour, Mrs. E. McKinnon; Sec., Mrs. D. R. Serl, 2855 Graham St.; Assist. Sec., Mrs. J. Shea; Treas., Mrs. N. P. McConnell, 1161 Old Esquimalt Rd.; *Committee Conveners: Membership*, Miss C. Strankman; *Visiting*, Miss M. Irving; *Social*, Mrs. M. Hoffmeister; *Rep.* to *Press*, Mrs. L. Banyard.

A.A., St. Joseph's Hospital, Victoria

Hon. Pres., Sr. M. Kathleen; Hon. Vice-Pres., Sr. M. Gregory; Pres., Mrs. N. Robinson; First Vice-Pres., Miss J. Johnson; Sec. Vice-Pres., Miss S. Becker; Rec. Sec., Miss L. Perron; Corr. Sec., Miss A. Abery, St.J.H.; Treas., Miss J. Dengler; *Councillors*, Mmes Sinclair, Welsh, Evans, Ridewood.

MANITOBA

A.A., St. Boniface Hospital

Hon. Pres., Rev. Sr. Clermont; Pres., Miss L. Thompson; Vice-Pres., Misses M. Wilson, M. McKenzie; Rec. Sec., Miss M. Lougheed; Corr. Sec., Miss B. McPherson, St.B.H.; Treas., Mrs. B. Smith; *Archivist*, Mrs. T. Hulme; *Committee Conveners: Visiting*, Miss D. Hurle; *Social*, Mrs. M. Gendall; *Membership*, Miss B. Sotkowsky; *Reps.* to: *M.A.R.N.*, Miss N. Craig; *Nurses' Directory*, Miss E. Gagnon; *Local Council of Women*, Miss S. Wright; *The Canadian Nurse*, Mrs. H. Lemoine.

A.A., Children's Hospital, Winnipeg

Hon. Pres., Mrs. G. S. Williams; Past Pres., Mrs. J. Kirby; Pres., Mrs. C. D. Gordon Barber; Vice-Pres., Mrs. Wright; Rec. Sec., Miss M. Jupp; Corr. Sec., Miss D. Roe, C.H.; Treas., Mrs. Noble; *Committee Conveners: Program*, Miss E. Fyffe; *Refreshment*, Miss H. Armstrong; *Membership*, Miss P. McConnell; *Visiting*, Miss Armstrong.

A.A., Misericordia General Hospital, Winnipeg

Hon. Pres., Rev. Sr. St. Bertha; Pres., Mrs. T. P. Hessian; Vice-Pres., Miss D. Ambrose; Sec., Miss J. Chisholm, 124 Chestnut St.; Treas., Mrs. J. A. Cutts; *Committee Conveners: Social*, Miss M. Ronnan; *Red Cross*, Mrs. V. McKenty; *Private Duty Section*, Misses S. Boyne, D. Sothern; *Rep.* to: *The Canadian Nurse*, Mrs. A. Thierry.

A.A., Winnipeg General Hospital

Hon. Pres., Mrs. A. W. Moody; Pres., Miss L. Gunn; Vice-Pres., Misses F. Waugh, R. Monck, J. Morgan; Rec. Sec., Miss H. Reid; Corr. Sec., Miss S. Ross, Ste. 10 Balmoral Crt.; Treas., Miss A. Smith, 806 Sherburn St.; *Committee Conveners: Program*, Mrs. F. Wilson; *Membership*, Miss V. Walker; *Visiting* Miss A. Aikman; *Journal*, Miss J. Simmie; *Archivist*, Miss L. Higginbottom; *Sandford Scholarship Fund*, Miss I. Cooper; *Reps.* to: *School of Nursing*, Miss F. Waugh; *Doctors' & Nurses' Directory*, Miss E. English; *Local Council of Women*, Mmes P. Randall, Thomas; *Council of Social Agencies*, Mrs. A. Speirs; *Red Cross*, Miss G. Hayden; *The Canadian Nurse*, Miss B. Hunt.

NEW BRUNSWICK

A.A., Saint John General Hospital

Hon. Pres., Miss E. J. Mitchell; Pres., Miss S. Hartley; First Vice-Pres., Miss M. Foley; Sec., Vice-Pres., Miss M. Scott; Sec., Miss K. Lawson, 140 Elliott Row; Treas., Mrs. A. E. Handren, Belmont, R.R. 1; *Executive*, Misses M. Murdoch, M. Ronald; *Conveners: Program*, Miss D. Wetmore, Mrs. Denyer; *Social*, Mrs. Lewin; *Flower*, Miss Selfridge; *Refreshment*, Mrs. B. Watt; *Publicity*, Miss I. Clark; *Visiting*, Mrs. A. Burns.

A.A., L. P. Fisher Memorial Hospital, Woodstock

Pres., Mrs. George King, Broadway; Vice-Pres., Mrs. W. B. Manzer, Chapel St.; Sec., Mrs. John Charters, Elm St.; Treas., Mrs. Elmer Arnold, Elm St.; *Executive Committee*, Mrs. Bertrum Gardiner, Prince William St.; Mrs. Thomas Everett, Union St.; Mrs. John Hale, Pine St.

NOVA SCOTIA

A.A., Halifax Infirmary

Pres., Miss O. Hayes; Vice-Pres., Miss N. Harley; Rec. Sec., Miss R. Butler; Corr. Sec., Miss M. Cragg, 14 Woodlawn Terrace; Treas., Miss G. Shortall; *Committee Conveners: Visiting*, Mrs. T. O'Leary; *Entertainment*, Mrs. J. Thornton; *Reps.* to: *Press*, Miss M. West; *The Canadian Nurse*, Miss R. Butler.

A A., Victoria General Hospital, Halifax

Pres., Mrs. V. Gormley, 446 Chebucto Rd.; Vice-Pres., Mrs. D. Luscombe; Sec., Miss Doris Brown, V.G.H.; Treas., Mrs. W. M. Hunt, 74 Jubilee Rd.; *Directors*, Mrs. S. Thompson, Misses E. Atkinson, D. Gill; *Social Committee*, Miss M. Ripley, Mrs. H. S. T. Williams; *Rep.* to: *The Canadian Nurse*, Miss D. Gill.

A.A., Aberdeen Hospital, New Glasgow

Hon. Pres., Miss Nina Grant; Pres., Miss Mabel Grant; Vice-Pres., Mrs. Claude Sutherland; Sec., Miss Vera MacIntosh, 154 Maple Ave.; Treas., Mrs. James Collie; *Rep.* to *Press*, Mrs. A. M. MacLeod.

ONTARIO

A.A., Belleville General Hospital

Hon. Pres., Miss E. Horton; Pres., Miss E. Sullivan; Vice-Pres., Misses A. Jones, R. Poole; Sec., Miss B. Sharland; Treas., Miss A. Howes; *Committee Conveners: Flower & Gift*, Miss M. Miles; *Social*, Misses D. McCall, M. Goodfellow; *Program*, Mrs. M. Devine; *Nominating*, Miss T. Gordon; *Reps.* to: *V.O.N.*, Mrs. C. Howie; *The Canadian Nurse & Press*, Miss U. McComb.

A.A., Brantford General Hospital

Hon. Pres., Miss J. M. Wilson; Pres., Miss H. Cuff; Vice-Pres., Miss O. Plumstead; Sec., Miss M. Patterson, B.G.H.; Treas., Mrs. J. Oliver; *Committees: Gift*, Misses J. Landreth, V. Buckwell; *Flower*, Misses M. Mulloy, L. Burtch; *Social*, Mmes A. Grierson, P. Smith; *Red Cross*, Mrs. A. Riddell; *Reps.* to: *Local Council of Women*, Mrs. E. Walton; *The Canadian Nurse & Press*, Miss D. Franklin.

A.A., Brockville General Hospital

Hon. Pres., Misses A. Shannette, E. Moffatt; Pres., Mrs. M. White; First Vice-Pres., Mrs. W. Cooke; Sec. Vice-Pres., Miss L. Markley; Sec., Mrs. H. Bishop, 89 King St. W.; Corr. Sec., Miss M. Arnold, William St.; Treas., Mrs. H. Vandusen; *Committees: Gift*, Miss V. Kendrick; *Social*, Mrs. H. Green; *Prop-*

erly, Mrs. M. Derry, Misses J. McLaughlin, M. Gardiner; *Annual Fees*, Miss V. Preston; *Rep.* to *The Canadian Nurse*, Miss H. Corbett.

A.A., Public General Hospital, Chatham

Hon. Pres., Miss P. Campbell; Pres., Mrs. H. Goldrick; Vice-Pres., Mrs. D. Nicholls, Miss E. Phillips; Rec. Sec., Miss E. Miller; Corr. Sec., Miss M. Gilbert, 220 St. Clair St.; Assist. Corr. Sec., Mrs. L. Judd; Treas., Miss D. Thomas; *Committees: Shopping*, Misses A. Head, E. Liberty, Mrs. G. Brisby; *Social & Refreshment*, Mmes J. C. MacWilliam, R. Bradley, Misses A. Hastings, M. Campbell; *Councillors*, Misses L. Baird, V. Dyer, M. McNaughton, A. Head; *Reps.* to: *Press*, Miss J. Murray; *The Canadian Nurse*, Mrs. M. Sheldon.

A.A., St. Joseph's Hospital, Chatham

Hon. Pres., Sr. M. Fabian; Hon. Vice-Pres., Sr. M. Valeria; Pres., Miss J. Coburn; Vice-Pres., Mmes B. Caron, L. Smyth; Sec.-Treas., Miss D. Carley; Corr. Sec., Miss A. Kenny, Aberdeen Hotel; *Councillors*, Misses H. Gray, L. Pettypiece, Mmes E. Roberts, E. Peco; *Committees: Lunch*, Miss M. Newcomb, Mmes H. Kennedy, M. O'Rourke; *Buying*, Mmes E. Roberts, E. Peco; *Program*, Misses M. Boyle, K. Kaufmann, Mmes C. I. Salmon, F. Doyle; *Reps.* to: *Press*, Miss K. Kaufmann; *The Canadian Nurse*, Mrs. M. Jackson.

A.A., Cornwall General Hospital

Hon. Pres., Miss H. C. Wilson; Pres., Miss C. Smirl; Vice-Pres., Mmes A. Snow, E. Wagoner; Sec.-Treas., Miss V. McMurray, 120 Adolphus St.; *Committee Conveners: Program & Social Finance*, Misses A. McNaughton, K. Brownell; *Flower*, Miss E. McIntyre; *Membership*, Miss Brownell; *Rep.* to: *The Canadian Nurse*, Mrs. G. Whitney.

A.A., Hotel Dieu Hospital, Cornwall

Hon. Pres., Rev. Sr. St. George; Pres., Miss D. Ryan; Vice-Pres., Rev. Sr. Mooney; Sec.-Treas., Miss H. Cleary; Corr. Secs., Miss A. Huot, St. Lawrence Sanatorium; Mrs. R. Ezard; *Committee Conveners: Music & Social*, Miss E. Young; *Gift*, Miss I. McDonell; *Publicity*, Miss U. Leblanc.

A.A., Galt Hospital

Hon. Pres., Miss Z. M. Hamilton; Pres., Miss H. Blagden; Sec., Miss Hilda Teather, Galt Hospital; Treas., Mrs. Vanstone; *Committee Conveners: Press*, Mrs. W. Bell; *Flower & Gift*, Mrs. J. Kersh; *Social*, Miss A. Park, Mrs. L. Maddock.

A.A., Guelph General Hospital

Hon. Pres., Miss S. A. Campbell; Past Pres., Mrs. C. McLeod; Pres., Mrs. W. Redmond; First Vice-Pres., Mrs. J. Tawse; Sec. Vice-Pres., Miss L. Brindle; Sec., Miss F. Cameron, 210 Woolwich St.; Treas., Miss K. Cleghorn.

A.A., St. Joseph's Hospital, Guelph

Mother Superior, Sr. M. Clotilde; Supt. of Nurses, Sr. M. Assumption; Pres., Miss E. Goetz; Vice-Pres., Miss H. Farrell; Sec., Miss M. Daley, 134 Ferguson St.; Treas., Miss J. Bosomworth, St.J.H.; *Entertainment Convener*, Miss B. Crimmins.

A.A., Hamilton General Hospital

Hon. Pres., Miss C. E. Brewster; Pres., Miss Ella Baird; Vice-Pres., Misses H. Fasken, E. Ferguson; Rec. Sec., Miss C. Leleu; Assist. Sec., Miss J. Tufford; Corr. Sec., Miss D. Pearce, H.G.H.; Treas., Miss N. Coles, 499 Main St. E.; Assist. Treas., Mrs. A. Smith; Sec.-Treas., Mutual Benefit Ass'n, Miss J. Harrison; *Committees: Executive*, Mrs. A. Massie (*conv*), Misses E. Bingeman, C. Inrig, G. Hall; *Program*, Misses M. Morgan (*conv*), M. Peart, I. Mayall, Mrs. McIntosh; *Flower & Visiting*, Mrs. Duncan (*conv*), Misses M. Payne, H. Currie; *Budget*, Misses G. Coulthart (*conv*), Coles, Mrs. M. Smith; *Membership*, Misses E. Gayfer (*conv*), Lang; *Publication*, Miss M. Irving; *Reps.* to: *R.N.A.O.*, Miss C. Inrig; *Local Council of Women*, Miss Coles; *Women's Auxiliary*, Mrs. Stephen.

A.A., Ontario Hospital, Hamilton

Hon. Pres., Miss K. E. Turney; Hon. Vice-Pres., Miss E. P. Dodd; Pres., Mrs. M. Sutherland; Vice-Pres., Mrs. G. Wallace; Sec., Mrs. I. Nichols, Apt. 7, 23 St. Matthews Ave.; Treas., Miss M. Shalla; *Committee Conveners: Social*, Mrs. A. Smith, Misses M. Smith, M. MacDonald; *Visiting*, Miss E. Lee; *Rep.* to: *Press*, Miss D. Parker.

A.A., St. Joseph's Hospital, Hamilton

Hon. Pres., Rev. Sr. M. St. Edward; Hon. Vice-Pres., Rev. Sr. M. Ursula; Pres., Miss L. Johnson; Vice-Pres., Miss F. O'Brien; Sec., Miss M. Minnes, 130 Hunter St. W.; Treas., Miss L. Leatherdale; *Executive*, Mrs. Muir, Misses V. Jennings, M. Pullano, N. Hinks, E. Quinn; *Reps.* to: *R.N.A.O.*, Miss K. Overholt; *Press & The Canadian Nurse*, Miss M. Haley.

A.A., Hôtel-Dieu, Kingston

Hon. Pres., Rev. Mother Donovan; Hon. Vice-Pres., Rev. Sister Rouble; Pres., Miss Ann Murphy; Vice-Pres., Mrs. L. Keller; Sec. Vice-Pres., Mrs. D. Regan; Sec., Miss Joan Gibson, 490 Brock St.; Treas., Mrs. A. Thompson; *Committees: Social*, Misses J. Coulter, M. Quigley; *Visiting*, Mrs. E. Kipkie, Miss M. Coderre.

A.A., Kingston General Hospital

Hon. Pres., Miss L. D. Acton; Pres., Miss Emma L. Sharpe, K.G.H.; First Vice-Pres., Miss Elsie Duncan, K.G.H.; Sec. Vice-Pres., Mrs. Gwen Hunt, 313 Collingwood St.; Sec., Miss G. B. McCulloch, K.G.H.; Treas., Miss Olevia M. Wilson, K.G.H.; Assist. Treas., Miss Emma MacLean, 313 Frontenac St.

A.A., St. Mary's Hospital, Kitchener

Hon. Pres., Sr. Mary Grace; Pres., Miss M. Hostetler; Vice-Pres., Miss A. Sobisch, Mrs. D. Campbell; Rec. Sec., Miss D. Marshall; Corr. Sec., Miss M. Monaghan, 94 DeKay St.; Treas., Miss B. Manley, 80 Union Blvd.

A A., Rose Memorial Hospital, Lindsay

Hon. Pres., Miss E. S. Reid; Pres., Mrs. I. Radman; First Vice-Pres., Miss G. Lehigh; Sec. Vice-Pres., Mrs. U. Cresswell; Sec., Miss A. Webber; Treas., Mrs. D. Elliott; *Committees: Red Cross Supply*, Miss L. Gillespie; *Program*, Mrs. Williamson, Miss A. Flett; *Refreshment*, Misses Pogue, C. Fallis; *Notification of Meetings*, Miss B. Marsh; *Rep.* to: *Press*, Miss Strath.

A.A., Ontario Hospital, London

Hon. Pres., Miss F. Thomas; Pres., Mrs. E. Grosvenor; Vice-Pres., Mmes P. Soutar, M. Duncan; Sec., Mrs. E. Bruner, 207 Mill St.; Treas., Miss N. Williams; Assist. Sec.-Treas., Miss L. Steele; *Committee Conveners: Social*, Mrs. P. Robb; *Social Service*, Mrs. M. Millen; *Flower Fund*, Mrs. E. Grosvenor.

A.A., St. Joseph's Hospital, London

Hon. Pres., Rev. Sr. St. Elizabeth; Hon. Vice-Pres., Rev. Sr. Ruth; Pres., Miss C. Murray; Vice-Pres., Mrs. P. Chapman, Miss M. Foxworthy; Rec. Sec., Miss E. Eckert; Corr. Sec., Miss M. Mahoney, 194 Cromwell St.; Treas., Miss F. Albert; *Conveners: Social*, Misses E. Haggerty, M. McGrath; *Finance*, Miss F. Albert, Mrs. M. McCormick; *Reps.* to: *Press*, Miss M. Walker; *Registry*, Misses M. Baker, E. Beger; *The Canadian Nurse*, Miss S. Gignac.

A.A., Victoria Hospital, London

Hon. Pres., Miss H. Stuart; Hon. Vice-Pres., Mrs. A. E. Silverwood; Pres., Miss M. Stevenson; Vice-Pres., Mmes V. Fry, R. Hagerman; Rec. Sec., Mrs. S. McGugan; Corr. Sec., Miss M. Sloan, 200 Central Ave.; Treas., Miss V. Watson, 384 Waterloo St.

A.A., Niagara Falls General Hospital

Pres., Mrs. Howard McGarry; Vice-Pres., Miss E. Smith; Sec., Miss Patricia Hobson, 665 Simcoe St.; Treas., Miss E. LaPlante; *Rep.* to: *R.N.A.O. & The Canadian Nurse*, Miss I. Hammond.

A.A., Soldiers' Memorial Hospital, Orillia

Hon. Pres., Miss Kilpatrick; Pres., Miss E. Dunlop; Vice-Pres., Misses E. McEwen, D. Gibney; Sec., Miss P. Dixon, Soldiers' Memorial Hospital; Treas., Miss L. V. McKenzie, 21 William St.; *Auditors*, Misses J. and M. MacLelland; *Directors*, Mmes Middleton, Hannaford, Miss Pearson.

A.A., Oshawa General Hospital

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A.A., Lady Stanley Institute (Incorporated 1918) Ottawa

Hon. Pres., Mrs. W. S. Lyman; Hon. Vice-Pres., Miss M. Stewart; Pres., Mrs. E. Oliver; Vice-Pres., Miss K. Pridmore; Sec., Mrs. R. B. Bryce, 147 Primrose Ave.; Treas., Mrs. C. Port, 362 Clifton Rd.; *Flower Convener*, Miss D. Booth; *Directors*, Misses P. Walker, A. McNiece, Mmes W. Caven, F. Low; *Reps.* to: *Community Registry*, Misses M. Slinn, M. Scott; *Press*, Miss G. Halpenny; *The Canadian Nurse*, Miss E. McGibbon.

A.A., Ottawa Civic Hospital

Hon. Pres., Miss G. Bennett; Pres., Miss I. Dickson; Vice-Pres., Misses P. Farmer, M. E. Keith; Rec. Sec., Miss M. Brown; Corr. Sec., Miss D. Ogilvie, 252 Metcalfe St.; Treas., Miss A. Napier; *Councillors*, Misses G. Wilson, G. Carver, M. Christie, L. Mawhinney, L. Currie, Mrs. Veitch; *Committees: Refreshment*, Mrs. True, Misses Horsey, Knox, Campbell; *Visiting & Flower*, Misses J. Milligan, G. Kennedy.

A.A., Ottawa General Hospital

Hon. Pres., Sr. Marie Alban; Pres., Sr. Madeleine de Jesus; Vice-Pres., Mmes N. Chassé, H. Racine; Sec., Miss J. Stock, 390 Chapel St.; Treas., Miss M. R. Nadon; *Councillors*, Misses V. Belier, G. Boland, H. Chamberlin, V. Foran, J. Robert, K. Ryan; *Reps.* to: *Registry*, Misses M. Landreville, M. Butler, A. Sanders; *Sick Benefit*, Miss J. Frappier; *D.C.C.A.*, Miss M. O'Hare; *Red Cross*, Mrs. A. Powers; *The Canadian Nurse*, Miss J. Stock.

A.A., St. Luke's Hospital, Ottawa

Hon. Pres., Miss E. Maxwell, O.B.E.; Pres., Mrs. A. Stewart; Vice-Pres., Mrs. R. Brown; Sec., Miss E. Honeywell, 50-2nd Ave.; Treas., Mrs. E. Swerdfager, 49 Glen Ave.; *Committees: Flower*, Mmes E. Pritchard, J. Harper; *Insurance*, Miss I. Johnston; *Nominating*, Miss N. Lewis, Mrs. J. McFarlane; *Reps.* to: *Community Nursing Registry*, Misses D. Brown, F. Meredith; *Local Council of Women*, Mrs. W. Creighton, Miss N. Lewis; *Press*, Mrs. R. Gamble; *The Canadian Nurse*, Miss I. Johnston.

A.A., Owen Sound General and Marine Hospital

Hon. Pres., Misses E. Webster, R. Brown; Pres., Miss Marjorie Kerr; Vice-Pres., Miss Lorraine Harris; Sec.-Treas., Miss Alice Cook, 436-12th St. W.; Assist. Treas., Mrs. Gladys Dewar; *Rep.* to: *R.N.A.O.*, Miss Pearl Sewell.

A.A., Peterborough Civic Hospital

Hon. Pres., Miss E. G. Young; Pres., Mrs. I. Walker; Vice-Pres., Mmes M. Pringle, W. Conway; Sec., Miss M. Renwick; Corr. Sec., Miss D. Pidgeon, P.C.H.; Treas., Miss E. Reid; *Editors*, Mrs. J. Thornton, Miss Pidgeon; *Committees: Flower*, Miss S. Beer; *Social*, Mmes F. Revoy, R. McIntyre; *Reps.* to: *Local Council of Women*, Mrs. W. McLaren; *Hospitalisation Plan*, Mrs. R. Taylor.

A.A., Sarnia General Hospital

Hon. Pres., Miss Rahno Beamish; Pres., Miss Olive Banting; Sec., Miss Elaine Dobson-Smith, S.G.H.; Treas., Miss Elizabeth F. Russell, S.G.H.; *Rep.* to: *The Canadian Nurse*, Mrs. Mary Elrick, 141 Penrose St.

A.A., Stratford General Hospital

Pres., Miss E. Wilson; Vice-Pres., Miss E. Stewart; Sec., Mrs. J. Robertson, 64 Grant St.; Treas., Miss M. McMaster; *Committee Conveners: Social*, Miss R. Cleland; *Flower*, Miss B. Schellenberger; *Program*, Miss G. Dahms.

A.A., Mack Training School, St. Catharines

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A.A., St. Thomas Memorial Hospital

Hon. Pres., Miss I. Stewart; Hon. Vice-Pres., Miss L. Johnson; Pres., Miss B. Pow; Vice-Pres., Mrs. E. Arleine; Sec., Miss E. Hudson, 20 Meda St.; Treas., Mrs. B. Evans, Memorial Hospital.

A.A., The Grant Macdonald Training School for Nurses, Toronto

Hon. Pres., Miss P. L. Morrison; Pres., Mrs. B. Darwent; Rec. Sec., Miss I. Lucas; Corr. Sec., Mrs. P. Jacques, 23 Fuller Ave., Toronto 3; Treas., Miss M. McCullough; *Social Convener*, Mrs. Smith.

A.A., Hospital for Sick Children, Toronto

Pres., Mrs. H. Clifford; Vice-Pres., Misses P. Norton, F. Watson; Rec. Sec., Miss Mary Heffelfinger; Corr. Sec., Miss I. Emmerson, H.S.C.; Treas., Miss D. Muckle; Assist. Treas., Miss H. Rolstin.

A.A., Riverdale Hospital, Toronto

Pres., Miss A. Armstrong; First Vice-Pres., Mrs. J. Bradshaw; Sec. Vice-Pres., Mrs. G. Bourne; Sec., Miss Olga Gerker, Riverdale Hospital; Treas., Mrs. T. Fairbairn, 98 du Vernet Ave.; *Conveners: Program*, Miss K. Mathieson; *Visiting*, Mmes C. Spreeman, H. Dunbar; *R.N.A.O.*, Miss M. Ferry; *Rep.* to: *The Canadian Nurse*, Miss A. Armstrong.

A.A., St. John's Hospital, Toronto

Pres., Mrs. M. Owen, 53 Turner Rd.; Vice-Pres., Miss E. Price, 97 Avenue Rd.; Miss F. Young, 227 Milverton Blvd.; Rec. Sec., Mrs. D. Nelles, 73 Springmount Ave.; Corr. Sec., Miss M. Turnbull, 83 Balloil St.; Treas., Mrs. P. E. Thring, 14 Glencastle St.

A.A., St. Joseph's Hospital, Toronto

Pres., Miss E. Longo; Vice-Pres., Misses H. Nightingale, E. Mulloy; Rec. Sec., Miss E. Izzo; Corr. Sec., Miss Lillian Johnson, St.J.H.; Treas., Miss R. McBride; *Councillors*, Misses U. Smith, A. Lamphier, V. Hamilton, S. Griffin; *Committee Conveners: Program*, Miss A. Tobin; *Membership*, Miss M. Kehoe; *Rep.* to: *R.N.A.O.*, Miss M. Kelly.

A.A., St. Michael's Hospital, Toronto

Hon. Pres., Rev. Sr. Margaret; Hon. Vice-Pres., Rev. Sr. M. Kathleen; Pres., Miss M. Regan; Vice-Pres., Misses K. Meagher, L. Riley, M. McGarrell; Treas., Miss N. O'Connor; Assist. Treas., Miss E. Cunningham; Rec. Sec., Miss C. Damon; Corr. Sec., Mrs. M. Forrester, 185 Glenholme Ave.; *Councillors*, Mrs. T. Scully, Misses E. Crocker, D. Murphy, K. Boyle; *Membership Conveners: Active*, Miss L. Huck; *Associate*, Miss L. Bonin; *Reps.* to: *Nursing Education*, Miss G. Murphy; *Public Health*, Miss M. Tisdale; *Central Registry*, Misses E. Crocker, T. Harrison, N. Corrigan; *Hospital Care Plan*, Miss V. Murphy, Mrs. A. Romano; *Local Council of Women*, Mrs. G. Rossiter; *Press*, Mrs. E. Richards; *The Canadian Nurse*, Miss M. Herbert; *Ed. & Assist. Ed.*, "*The News*", Miss K. Boyle, Mrs. M. Neville.

A.A., School of Nursing, University of Toronto

Hon. Pres., Miss E. K. Russell; Hon. Vice-Pres., Miss F. H. M. Emory; Past Pres., Miss J. Leask; Pres., Miss Elvira Manning; First Vice-Pres., Miss H. Carpenter; Sec. Vice-Pres., Miss E. Dick; Sec.-Treas., Miss Ethel Greenwood, 932A Avenue Rd.

A.A., Toronto General Hospital

Pres., Miss D. Percy; Vice-Pres., Misses M. Winter, M. Fry; Sec.-Treas., Miss L. Shearer, 12 Hewitt Ave.; *Councillors*, Mmes R. E. Will, G. Fraser, H. A. McCaghey, Miss F. Robertson; *Committee Conveners:*

Program, Miss S. Burnett; *Social*, Miss M. Dix; *Gift*, Miss M. Fry; *Scholarship*, Miss M. Winter; *Trust Fund*, Miss M. Markle; *Flower*, Mrs. W. S. Hodgens; *Membership*, Miss S. Sewell; *Nominating*, Mrs. G. Coombs; *Alumnae Room*, Miss L. Bailey; *Reps.* to: *Red Cross Club*, Miss M. Dulmage; *Press*, Mrs. D. A. MacLachlan; *Archivist*, Miss J. M. Knisely; *Ed. "The Quarterly"*, Miss M. J. B. Thompson; *Treas., Plan for Hospital Care*, Miss M. Huntaman; *Pres., Private Duty Group*, Miss M. Dix.

A.A., Training School for Nurses of the Toronto East General Hospital with which is incorporated the Toronto Orthopedic Hospital

Hon. Pres., Miss E. MacLean; Pres., Miss L. Warman; Vice-Pres., Miss J. Collins; Sec., Miss M. Angus, T.E.G.H.; Treas., Miss N. Pike, T.E.G.H.; *Committee Conveners: Social*, Miss F. Kane; *Program*, Miss M. Hemnsworth; *Reps.* to: *Nurses Registry*, Misses E. Campbell, M. Jennings; *The Canadian Nurse*, Miss J. Collins.

A.A., Toronto Western Hospital

Hon. Pres., Miss B. L. Ellis, Mrs. C. T. Currie; Pres., Mrs. I. Kruger; Vice-Pres., Miss M. Agnew; Rec. Sec., Miss B. Passmore; Corr. Sec., Mrs. T. A. Robinson, 41 Pinewood Ave.; Treas., Miss M. Patterson; Assist. Treas., Miss J. Finlayson; *Councillors*, Mrs. C. MacMillan, Misses G. Jones, L. McDougall, Walters, J. Wallace, M. Hood; *Committees: Program*, Misses K. Wood (*conv*), A. Perry, B. Miles, Mrs. B. Vale; *Budget*, Mmes H. Kay (*conv*), Chant, Miss B. Shutz; *Social*, Mmes H. Brown, Boadway, Miss F. Matthews; *Scholarship*, Misses M. Malloy, A. Bell (*convs*), E. Bolton, M. Thomaa, Mrs. Davies; *Visiting*, Mrs. H. Norman (*conv*), Misses E. Taylor, Cerswell; *Membership*, Mrs. Chant (*conv*), Misses Higginson, A. Smith; *Reps.* to: *Local Council*, Miss L. McDougall; *R.N.A.O.*, Miss M. Brown; *W.P.T.B.*, Mrs. C. MacMillan; *The Canadian Nurse*, Miss E. Titcombe.

A.A., Wellesley Hospital, Toronto

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